Inform and Empower: Improving India's Health Systems

A Senior Honors Thesis

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by

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Abstract

Despite India's rapid growth in the past decade, large disparities in health outcomes and health service utilization between the poor and the better off still exist. Furthermore, large disparities also exist between rural and urban areas. In this study I argue that skewed political incentives due to clientelism and a lack of accountability are the cause of these disparities. I contend that the central problem in the inequities is that people lack information about preventive health measures, about appropriate health services, and about how to demand better health services. Without proper information, individuals cannot demand the health services that they are entitled to. Thus, the strategy is to inform and empower the individuals.

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This thesis has been perhaps one of the most gratifying and comprehensive projects that I have ever undertaken, and it has been a journey through which I have grown both as a person and a scholar. Perhaps the most significant aspect of this project was the opportunity that I was afforded to travel to India to meet with the individuals for whom this study was created in the first place. It is with the hope of expressing their perspectives that I have conducted this study. In the end, this has been an attempt not just to construct an academic study, but rather, it has been an endeavor to in some way contribute to the improvement of these individuals' livelihoods.

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Table of Contents

CHAPTER 1: INTRODUCTION

Health is a vital and fundamental instrument of international development. Three of the eight Millennium Development Goals pertain to health, a testament to its crucial role in development. Poor health serves as a severe impediment to enabling individuals to escape poverty, as proper health is essential for an individual to be productive. In using panel data for Indian states, Gupta and Mitra (2004) show that economic growth and population health are positively correlated and have a bi-directional relationship. Thus, better health stimulates economic growth by increasing productivity and increased growth improves the health status of a population. As such, it is clear that the improvement of health is essential not only by itself, as a basic human right, but also as an impetus for increased economic growth and reduced poverty of nations. India in particular faces a situation where much of its population still lacks access to adequate health services.

Since the liberalization of its economy in 1991, India has witnessed one of the world's fastest rates of economic growth. However, despite India's high level of growth, problems of poverty and inequity still persist. Overall, India still ranks 127 out of 177 countries in the Human Development Index.[1] In regards to its health status, although India has seen significant improvements in its people's health over the last fifty years, there are numerous health problems that still remain at unsatisfactory levels. While overall health outcomes are quite weak, there are also large inequalities in both health outcomes and health service utilization, which will be explored extensively in this study. In addition, there are large disparities between urban and rural regions, and between different states in

[1] Human Development Report (2005)

India.[2] In rural areas especially, poor individuals face disproportionately large burdens from weak public health services and unaffordable private services. Furthermore, because individuals in these rural areas generally lack knowledge about adequate services, and because they very infrequently participate in community-based organizations, they face an inability to move towards the collective goal of ensuring access to proper health services.

Diverse and at times as paradoxical as India often is, its health care system is perhaps equally as varied. An underlying, yet poorly understood fact, is that in terms of the *level* of health care provision, the system can theoretically adequately serve India's entire population (Jesani and Anantharam 1993; Jesani and Nandraj 1994; Jesani 1998). However, what leads to weak health outcomes among India's poor is the *distribution* of health care provision, which has more to do with politics than it does with medical care itself. Thus, the focus of prescribed solutions should be on transforming the political incentives and structures to ensure universal access to health services to all of India's poor. This must be achieved with a combination of two mechanisms: increasing the demand among the rural poor for proper health services and increasing the political will of government officials to create and implement pro-poor policies by increasing accountability and decreasing clientelism.

The proposed solutions for improving the health status of India's population have centered predominantly on top-down, supply-side economic reasoning. While it is the world's largest democracy, India also continues to face an entrenched and corrupt bureaucracy, barring the poor—especially those in rural regions—from exercising their freedom to political, economic, and social well being. The problem with proposed solutions

[2] National Family Health Survey III: 2005-2006

is that they continue to operate *through* this corrupt bureaucracy, diminishing their effectiveness. What is needed, therefore, is a higher focus on solutions that are bottom-up and demand-driven. These solutions need to actively incorporate the actions and the opinions of the poor, since ultimately, it is a matter of their livelihoods. The aim, therefore, is not to *save* the poor from circumstances; rather, the aim is to raise the voice of the poor so that they *themselves* can ensure that they can fulfill a livelihood that they have reason to value.

One of the most powerful mechanisms to empower the poor is the dissemination of information. In this study, the focus is on information pertaining to health, which I will expand on in the next two chapters. The form of information that is perhaps most salient is that about individual entitlements to adequate health care, and about how to demand these entitlements both from health providers and government officials. Participating in community-based associations is a powerful method to facilitate this type of interaction. Dissemination of information, then, is the mechanism that can both generate demand and encourage the creation and implementation of pro-poor policies. When comparing Kerala and Uttar Pradesh, two states in India exhibiting starkly different health outcomes, Dreze and Sen (2002) propose that Kerala's success is the result of public action that promoted extensive social opportunities and equitable provision of public services. In contrast, they argue that Uttar Pradesh's failures can be attributed to the public neglect of these very same opportunities.

Some argue that the provision of primary information should not take precedence over directly ensuring that health services reach the poor.[3] I argue that the provision of this

[3] Jenkins & Goetz (1999). Jenkins and Goetz discuss three types of rights. The "first-

primary information, such as documentation and actions of the government, *should* be provided to individuals on its own. Moreover, when this information is about how to demand better services from the government and from health providers, it is even more relevant and necessary. Furthermore, the aim of this information is not only to improve individual access to health care services, but also to promote political participation in a country where democratic mechanisms should enable individuals to voice their opinions and complaints.

In Development as Freedom, Amartya Sen (1999) argues that there are five distinct types of freedoms: political freedoms, economic facilities, social opportunities, transparency guarantees, and protective security. Each is an equal, constitutive element of development, and each is required for an individual to live a life outside the confines of poverty. The most pertinent point here is that each of these freedoms has a "remarkable empirical connection (11)" to each other. Political freedoms in particular are those freedoms that enable individuals "to determine who should govern and on what principles, and […] to scrutinize and criticize authorities, to have freedom of political expression and an uncensored press… (38)." While development experts often diminish the importance of political freedoms, it is precisely these political freedoms that can help to promote economic security and ensure social opportunities. The argument in this study is that these political freedoms are predicated on the dissemination of information.

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generation" civil-political rights pertain to the individual citizen's relationship to the state. The "second-generation" rights are based on demands that the state recognize a right to basic economic necessities like food, shelter, education, and healthcare. Finally, the "third-generation" rights are "group rights", and they pertain to communities and their entitlements to cultural preservation and autonomy.

This study is divided into seven chapters. The following chapter describes India's health system, with a focus on the current overall health status of its population and the structure of the health system. This chapter will also review both the arguments for why India's current health system is faltering and the solutions proposed to help fix it. In Chapter 3 I develop the theory of information dissemination and also provide a political framework for the argument. I also stress the importance of community-based organizations in facilitating the use of information to demand better health services. In Chapter 4 I use regression analysis to analyze data collected from surveys administered in Andhra Pradesh. This chapter provides quantitative evidence for the information dissemination theory. Chapter 5 is a case study of a specific NGO—Healing Fields Foundation—currently operating in India, working extensively on health education in both rural and urban regions. This case study is based both on interviews that I conducted and background research on the NGO. In Chapter 6 I articulate a definition for what a pro-poor policy is, develop a metric for what constitutes a pro-poor policy, and apply the metric by evaluating whether specific current Indian health programs are actually pro-poor. Lastly, Chapter 7 concludes by summarizing the findings of this study and discussing its implications for improving the health status of individuals living in poverty in rural India.

Chapter 2: Health Care in India

India's commitment to providing health care to all of its citizens is seemingly quite weak. While significant strides have been achieved in terms of the health status of its population in the past five decades, health indicators remain stubbornly dismal. Most pertinently, health outcomes among the poor are disproportionately worse, and inequities in outcomes between the poor and the better off, and between urban and rural regions of India are prominent and substantive. It is vital to understand that India's health care system itself is theoretically sufficient to support all of its citizens (Jesani and Anantharam 1993; Jesani and Nandraj 1994; Jesani 1998). However, most services accrue to the non-poor, and it is politics that ultimately preclude balanced health indicators among all individuals. While past and current government rhetoric suggests that the government is committed to ensuring adequate health for all its citizens, their actions and implementation of programs suggest something to the contrary. Thus, the solution lies in ensuring increased political will to target adequate health services to the poor.

The aim of this chapter, then, is to outline the current health situation in India, diagnose the problem, and develop a context so that the prescribed solution to these health inequities and the ensuing argument are relevant. This chapter is organized into three sections. The first section describes the current state of India's health care system and the health status of its population, with a specific focus on the disparities in health outcomes and health service use between the poor and the better off and disparities between rural and urban regions. The subsequent section will explain the structure of India's health system, with particular attention paid to the systems in place for rural areas. It will also provide a historical context for the health system and discuss the current legislative

situation. With this descriptive framework in place, the final section will review the previous explanations and arguments in the academic literature for why health outcomes are so weak in India, particularly for its poor. I will argue that these explanations on their own are inadequate, and they ignore fundamental, demand-driven reasons centered on information dissemination for why health outcomes are disproportionately weak for the poor.

India's health woes remain wide and varied, as different states are at different points in the health transition path. This path is characterized by: a demographic component based on the lowering of mortality and fertility rates and the growth of an aging population; an epidemiological component based on changes in disease prevalence from communicable to non-communicable diseases; and a social component through which people gain greater knowledge about the health system and how to personally manage their own health (Peters, David H. et al: 2002). However, despite the fact that different states are at different points in the health transition path, and therefore face different health challenges, India as a whole still faces a significant health burden from communicable (infectious), preventable diseases, which the poor overwhelmingly face. In fact, communicable diseases account for 56% of the burden of disease for India, measured by years of life lost, while non-communicable diseases and injuries account for 30% and 14%, respectively.[1]

While infant mortality rates in India are visibly declining, they are still unacceptably high, particularly for the poor and for individuals living in rural areas. Currently, the infant

[1] World Health Organization India: Health Profile. <http://www.who.int/countries/ind/en/>

mortality rate is 57 deaths per 1,000,[2] which is a decline from 1999, when the rate was 68 deaths per 1,000.[3] While in absolute terms this rate is high, in relative terms this rate is still too high as well: China has an estimated current infant mortality rate of 20, Brazil a rate of 23, and Russia a rate of 11 deaths per 1,000. Disparities between rural and urban regions in India are salient: between 2001 and 2005, the infant mortality rate was 50% higher in rural areas (62 deaths per 1,000 births) than in urban areas (42 deaths per 1,000 births).[4] In addition, the perinatal mortality rate, which includes stillbirths and very early infant deaths (in the first week of life), is estimated at 49 deaths per 1,000 pregnancies that lasted 7 months or more. Perinatal mortality is also very high for very young mothers (67 deaths per 1,000) and for first pregnancies (66 deaths per 1,000). Furthermore, perinatal mortality is highest for rural mothers, less educated mothers, and mothers in the lowest wealth quintile.[5]

Under-5 mortality rates depict highly prevalent inequities between the poor and the better off. While for the poorest 20% of India's population the under-5 mortality rate is 101 deaths per 1,000, for the wealthiest 20% of the population the rate is 34 deaths per 1,000.[6] Moreover, whereas the under-5 mortality rate in urban areas is 52 deaths per 1,000, in rural areas the rate is 82 deaths per 1,000.[7] The causes of deaths in children under 5 were due almost entirely to diseases that are preventable: 39.8% were due to perinatal conditions, 19.8% due to diarrhea, 14.1% due to pneumonia, and 5.7% due to measles.[8] As

[2] National Family Health Survey III: 2005-2006
[3] National Family Health Survey III: 1998-1999
[4] National Family Health Survey III: 2005-2006
[5] ibid.
[6] World Health Organization India: Health Profile
[7] ibid.
[8] ibid.

further indication of the current health status of India's citizens, the estimated current life expectancy at birth is 66 years.[9] Life expectancy at birth in China is 73, and in Brazil is 72 years.[10]

Maternal care is very poor in India, and it further highlights the disparities that exist in health service utilization between the wealthy and the poor. National surveys administered in 2005-2006 depict this: only 50.7% of mothers had at least 3 antenatal care visits for their last birth (42.8% in rural versus 73.8% in urban); 36.8% of mothers received postnatal care from trained health personnel within 2 days of delivery for their last birth (28.5% in rural versus 60.8% in urban); 40.8% of mothers had institutional births (31.1% in rural versus 69.4 in urban); and 48.8% of mothers gave birth (refers to previous two births) while assisted by trained health personnel (39.9% in rural versus 75.3% in urban).[11] Inequities are very high between income quintiles: while 89.9% of the wealthiest quintiles of individuals gave birth while assisted by trained health personnel, only 19% of the poorest quintiles gave birth while assisted by trained health personnel.[12] For 72% of deliveries that took place at home, the mother reported that she did not feel that it was necessary to deliver in a health facility, and for more than a quarter (26%), the mother said that delivery in a health facility is too expensive.[13]

While utilization of maternal care services is low, the quality is also often low: only 22.3% of mothers consumed iron folic acid supplement pills for 90 days or more when they were pregnant with their last child (18.1% in rural versus 34.5% in urban); less than three

[9] CIA World Factbook, "India."
[10] ibid.
[11] National Family Health Survey III: 2005-2006
[12] World Health Organization India: Health Profile
[13] National Family Health Survey III: 2005-2006

in four had their abdomen examined; less than two in three received other services, including being weighed, having blood pressure measured, and having urine and blood samples checked; and only 36% received information about pregnancy complications.[14]

Furthermore, the rate of child immunization is revealing not only of the aforementioned disparities, but also the generally low level of health service utilization. Children are considered fully immunized if they receive one BCG injection to protect against tuberculosis, three doses each of DPT (diphtheria, pertussis, tetanus), polio vaccines, and one measles vaccine. Only 44% of children aged 12-23 months are fully vaccinated.[15] These rates are quite low, despite the fact that they have increased in the past decade. Furthermore, again, large disparities exist between the poor and the better off: among individuals in the wealthiest quintile, 85% of children under the age of 1 received measles immunization, while among individuals in the poorest quintile, only 40% of children under the age of 1 received measles immunization.[16]

In addition, while malaria and tuberculosis are diseases that national programs have had significant success in controlling, the increasing prevalence of HIV/AIDS threatens to undo much of the improvements that India's health system has made in the past few decades. Although the National Malaria Control Programme was successful in controlling malaria up to the 1970s, when there were only 100,000 malaria cases left, the disease has since reemerged as an epidemic in India (Bajpai and Goyal 2004), as 2.01 million malaria cases were reported 2001.[17] In regards to tuberculosis (TB), India accounts for almost a quarter of TB cases in the world (ibid). The Revised National Tuberculosis Control

[14] National Family Health Survey III: 2005-2006
[15] ibid.
[16] World Health Organization India: Health Profile
[17] Economic Survey: 2002-2003

Program, launched in 1993, is one of the largest public health programs in the world and has been successful at controlling the disease. While 445 per 100,000 individuals suffer from TB, 418 per 100,000 individuals have been medically treated for TB.[18] However, any success that has been made in containing TB is increasingly threatened by the increased incidence of HIV/AIDS, which creates susceptibility to TB and afflicts 290 out of every 100,000 individuals in India.[19]

Thus, these indicators show quite clearly the stark differences in health care outcomes and health service utilization between the wealthy and the poor and between urban and rural areas. Again, this does not signify necessarily an underdevelopment of India's health system; instead, it points more towards the skewed distribution and capture of resources by the better off, which deserves a more careful analysis. In discussing the structure of India's health system, there are three elements of the system that need to be taken into consideration. First is the fact that there are such different levels of utilization of services between individuals with different income levels. Second, not only are India's public health services under resourced, but also private services are highly unregulated and expensive for the majority of the population. The greater use of private services rather than public services leads to a high level of provision of curative services instead of preventive, public health services. This focus on curative services, and the ensuing negative consequences, is the third point that will underlie the following discussion of the structure of the country's health care system.

The public health system in India can be divided into three levels: national, state, and district. At the national level, the Ministry of Health and Family Welfare is the Indian

[18] National Family Health Survey III: 2005-2006
[19] World Health Organization India: Health Profile

government ministry that creates health policy and is responsible for all government programs relating to family planning in India. This Ministry has three departments: Department of Health, Department of Family Welfare, and Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy (AYUSH). Furthermore, there are fourteen National Health Programs, including those for HIV/AIDS, malaria, and tuberculosis. Although under the Indian Constitution the central, state, and district levels of government share the responsibility for public health, the delivery of public sector health services is effectively a state responsibility. At this state level, the organization is under the State Department of Health and Family Welfare. The district level serves as the intermediary between the state level and the peripheral level, which is composed of the CHCs, PHCs, and subcenters. The district level and the health and family welfare programs are headed by the District Medical and Health Officer (DMHO). They are responsible for implementing the program according to policies laid down and finalized at higher levels.

The periphery, or the rural area, is composed of levels of health care as well. The topmost level is the community level, which is composed of one Community Health Center (CHC), established for 80,000 to 120,000 individuals.[20] This center provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics, and gynecology. At the next level are the Primary Health Centers (PHC), which are supposed to cover approximately 30,000 individuals each, including those living in tribal areas. Finally, at the bottom most level are the subcenters, which are supposed to cover 5,000 individuals each and are supposed to be manned by one male and one female multi-purpose health worker. Generally, there is one subcenter per village. The subcenters and the PHCs are supposed to

[20] World Health Organization India: Health Profile

be the first point of contact for individuals living in rural areas, and these health facilities are charged with providing largely preventive instead of curative services, to be discussed in more detail shortly.

The public health service sector is both vast and under resourced, particularly in terms of government funding, which is abysmally low: India currently spends 5.2% of its GDP on health, of which public health expenditure is less than 1% of GDP, the rest being accounted for by private expenditure.[21] In comparison, other developing countries on average spend approximately 3% of their GDP on public health, while developed countries on average spend about 5% of their GDP (Sachs and Bajpai 2001). Moreover, while the public sector is indeed large, the private sector still constitutes the majority of India's health care system: there are a total of approximately 70,000 hospitals, 93% of which are in the private sector, and 1.2 million total hospital beds, 65% of which are in the private sector. Further, approximately 85% of all doctors are in the private sector (Jesani).

While the majority of health services are provided by the private sector, the public spending that does occur focuses largely on curative services rather than preventive health services, which are more cost-effective and far-reaching. Public spending also accrues mostly to the non-poor: The poorest 20% of the population only captures about 10% of the total net public subsidy, and the richest quintile benefits three times more than the poorest (Mahal et. Al 2001). There are two reasons for why this spending accrues more to the rich than the poor. First, the better off seek and utilize the services at higher rates for various reasons. Second, there are differences in the types of health services utilized by the poor and the non-poor. While the rich are much more likely than the poor to use hospital-based

[21] National Health Policy: 2002

services, both inpatient and outpatient, the poor are slightly more likely to attain outpatient care from primary health care (PHC) facilities (ibid). In addition, 66% of the hospital bed days for those below the poverty line took place in public facilities compared to only 44% of the bed days for those above the poverty line (ibid). Inpatient care requires hospitalization, while outpatient care can be provided simply by a visit to a clinic.

The poor, therefore, face a double burden. Public health facilities are generally under resourced and under funded, leading to low quality of care. Because the poor face low quality of care from these public facilities, they often turn to private health facilities instead. For example, while the poor utilize PHCs more than the rich for outpatient care, they still seek private health facilities almost 80% of the time (Peters et al. 2002). Utilizing private facilities instead of the free public health facilities causes an additional large financial burden on poor individuals. In fact, hospitalization causes a large financial burden on *all* individuals, with close to 25% of hospitalized Indians falling into poverty from medical costs in 1995 necessitating an insurance mechanism (ibid).

India's health systems face an additional challenge in that the entire system is based more so on curative services instead of preventive services. This has occurred despite the persistent rhetoric promoting preventive care. In rural areas in particular, effective implementation of preventive care can have profound effects for the health of individuals living in these regions, and therefore, strengthening of PHCs and subcenters is vital for improving health in rural regions. The significance of primary health care became publicly prominent with the WHO Alma Ata Declaration in 1978. The Declaration recommended that primary health care should include: education concerning prevailing health problems and methods of identifying, preventing and controlling them; maternal and child health

care, including family planning; immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries. Furthermore, it emphasized the need for linking of the primary care with strong secondary and tertiary level care. The Declaration also called for organized community participation and self-reliance among individuals, families, and communities in order to assume more responsibility for their own health, facilitated by community based organizations. Subcenters and primary health centers, therefore, are important not only because they are supposed to offer preventive measures, but also because they are the first line of contact for most rural populations. Thus, I will focus largely on these facilities.

The Indian government recognized very early the need to base primary health care, particularly in rural areas, on preventive services. Action on the realization that preventive health care is vital has been missing, however. With the Bhore Committee in 1946, the Indian government asserted that the health program in India be developed on a foundation of preventive health work. The Committee strongly recommended a health services system based on the needs of the people, the majority of whom were deprived and poor, it said. It declared the development of a strong basic health services structure at the primary level with referral linkages. In addition, it identified the importance of community participation in promoting both preventive and curative services. Since then, there have been constant five-year plans, developed regularly to map the goals and the economic path of India. In terms of health, each plan has focused largely on preventive care, including the most recent 11th five-year plan, which again places a focus on marginalized groups and on public health measures.

Despite these guidelines, however, there has been a general lack of health laws to govern the functioning of the health system. No health laws or regulations exist to fix market failures, which occur inevitably when the private sector provides most of the health services. Further, there are no laws for continuing medical education and competency for medical practitioners. A lack of laws has allowed the private sector to proliferate, completely unfettered and unregulated by the government. The solution lies not in strongly regulating the private sector, however. Rather, the government must look for avenues to promote public-private partnerships. Most importantly, while the intentions of sustaining high health outcomes among the poor are outlined in the Five Year Plans, the government must ultimately implement the plans through increased political will. The National Rural Health Mission, launched in 2005, is the government's newest initiative for attempting to improve health outcomes for the rural poor. I will discuss this program in much more depth in Chapter 6. Finally, there are two primary arguments advanced in the literature either for why the health care system in India is so weak: lack of sufficient resources, such as doctors and health care facilities, and lack of funding. In addition, recent literature has hailed the importance of decentralization as a mechanism to improve health service delivery to the rural poor.

The argument that there is a lack of sufficient resources does not hold well when we look at statistics for the numbers of hospitals and doctors. Again, there is, however, a very skewed distribution of these health workers. While the number of physicians per 10,000 individuals for the world is 1.5, for India it is 7, which is at par with low-income countries, and for public sector, the figure is only 2 physicians per 10,000.[22] There is, admittedly, a

[22] World Health Organization India: Health Profile

strong shortage of nurses: the number of nurses per 10,000 individuals in India is 8, while it is 33 for the world and 16 for low-income countries.[23] The country produces over 25,000 doctors annually in modern system of medicine and a similar number of homeopathy practitioners, nurses as well as para-professionals. Furthermore, in 2001 there were 137,311 subcenters and 22,842 PHCs.[24] With a rural population of about 740 million, this equates to approximately one subcenter per 5400 individuals and one PHC per 32,000 individuals. While the basic infrastructure and facilities may be sufficient, and while there are enough doctors throughout India, the skewed distribution of these doctors away from rural areas and the generally very poor qualities of these services leads to disparities in health outcomes between urban and rural areas and between the poor and non-poor.

Perhaps, many argue, this skewed distribution of doctors and resources is a result of under funding at the federal level. Admittedly, higher funding does help to explain the variation in health status in part. However, distribution of funding is also important, as much of the public spending accrues to the non-poor. Alternatively, maybe the barrier to adequate health care is actually at the individual level, having to do more with low per capita income. This is a step in the right direction. It is true that increased income is correlated with increased use of health services. However, again, this does not completely explain the variation in health outcomes and health service utilization in India. Kerala provides a strong example to the contrary, where strong health outcomes and high education levels occurred despite just an average per capita income, as compared to all of

[23] World Health Organization India: Health Profile
[24] World Health Organization India: Health Profile

India.[25] In contrast, Punjab, which is one of the wealthiest states and has one of the highest rates of per capita income,[26] has much weaker health indicators. Prabhu and Sadarshan (2002) state, "…higher average levels of income do not necessarily imply lower levels of income poverty and human poverty. Political commitment in terms of government expenditures on social services is an important variable that explains variations in human poverty across states (9)." Thus, it is politics, and not necessarily the medical care itself, that prevents balanced health indicators between the poor and non-poor.

The Indian government has actually already realized this fact, because of which it has strongly supported decentralization through the 73rd amendment in 1993. While the aim of decentralization is correct, the mechanism through which it hopes to attain that result is not completely effective. The aim of decentralization is to bring delivery of public services, including health, into the hands of the local governments (*Panchayati raj*) and closer to rural populations. Decentralizing provision of basic services has the advantage of overcoming information asymmetries, being rooted in the local context, increasing accountability of government officials, and enabling higher levels of community participation to directly monitor the public health services. While decentralization is a strong step in the right direction towards increasing accountability of both government officials and health providers, there are three reasons for why it cannot by itself improve health outcomes in rural areas: there is a lack of fiscal capacity for the Panchayat, there is a lack of administrative capacity for the Panchayat, and because ultimately, decentralization

[25] See the official website of the Chandigarh Administration. <http://sampark.chd.nic.in/images/statistics/SDP2005R6.pdf>. In 2005-2006, for example, Kerala had a per capita income of Rs 12,109 ($259), while the average per capita income for all of India was Rs. 11,799 ($252).
[26] Ibid. Punjab ranked 3rd out of all states in 2005-2006 in terms of per capita income at Rs 15,800 ($338).

is still a top-down solution that does not directly empower citizens to participate more actively in India's democracy.

The first challenge that decentralization faces is an inadequate transfer of financial power to the local governments. Local governments are highly dependent on financial transfers from higher levels; however, these transfers are often inadequate, leading to a mismatch between expenditures and revenue at the local government level. In 2005-2006, aggregate local-government spending was only about 5% of total government spending at all levels, while local revenue from own sources was only 1% of total government revenue (Singh 2008). Local governments are also often denied funds to which they are entitled, through long delays in release of the money by the state governments. Furthermore, local governments can neither take loans from state governments nor impose taxes. Finally, not only do local governments have very limited financial resources, but they also hold almost no autonomy even in terms of spending the money they receive from the state governments (Chhibber 2001).

In addition, despite the push for decentralization, local governments also lack political and administrative control, as it is controlled more by the state than it is autonomous. This is in part a result of the absence of clearly defined power and responsibilities for the Panchayat bodies: "…in the absence of financial resources or clearly defined powers and responsibilities, most Panchayat bodies have tended to become the executing agents of state bodies (Mahal and Srivastava 2000)." Furthermore, the fact that elections to Panchayats in many states have been held infrequently, or not at all, has eroded further their legitimacy and credibility as a force for promoting state accountability (ibid). Local governments, therefore, have little power or authority in most issue areas and have

few discussions with central or state officials on local matters (Chhibber 2001). In contrast to the relationship between the national and state governments, states refuse to cede significant power to the local governments.

Additionally, existing power structures at the local level often create a hindrance to achieving effective public delivery to the general populace of social services, infrastructural facilities, and conditions conducive to local business development (Bardhan 2002). Local governments are often at the mercy of local power elites, and thus, for decentralization to be successful, these existing structures of power within communities must change. Decentralization is ultimately about bringing services closer to the citizens, and about empowering them to participate more in the process of provision of these services. Therefore, not only must the influence of local power elites be diminished, but also the voice of the citizens themselves must be enhanced.

These two challenges of decentralization—a lack of fiscal and administrative capacity—have strong negative implications for public service delivery in rural regions, particularly for health services. Perhaps the most egregious in terms of health services is the fact that personnel working in both schools and primary health facilities generally do not report to elected local representatives, as they are not accountable to them. Rather, their salaries are directly payable by the appropriate state department. Furthermore, decisions about construction of new primary schools and health centers and their geographic location usually take place at the level of the District Planning Committee and above, so that local representatives have little or no say in the matter (Mahal and Srivastava 2000). In interviews of local elites in Maharashtra, Gujarat, and UP, almost half

of the local elites said that the local government had insufficient power and autonomy to deal with matters of health (Chhibber 2001: 35).[27]

The last reason for why decentralization cannot by itself improve health outcomes among the poor in rural India is that it ultimately is still is a top-down solution that does not involve the poor as much as it needs to. Decentralization is a correct first step to ensuring adequate public service delivery in a country that is as geographically and culturally diverse as India, where the health and education needs of the people differ greatly by climatic region, religion, caste, language, and a host of other socioeconomic characteristics. By bringing the accountability mechanism closer to the people, the individuals can build the capacity to directly monitor the primary health services available to them. However, while it should address information asymmetries in terms of contextualizing the necessary public services to the specific environment in each village, the process of decentralization still does not work *through* the citizens themselves. Therefore, I argue that increased information among the individuals themselves about proper health and about how to demand adequate health care from both local government officials and health providers is necessary to improve health outcomes among the rural poor. While decentralization greatly facilitates this process, for it to be fully effective, it must be undergirded by increased information dissemination. Rani Mullen illustrates this well: "Decentralization in India is thus not a panacea for the lack of accountability of local governments. But decentralization set up structures that were more likely to mobilize awareness of rights and actions to attain these rights over the longer term (299)."

[27] In this survey, "local elites" included officeholders of block offices, other local influential bureaucrats and politicians, block development officers, village extension officers, and leaders of parties and other influential organizations.

If health care provision is viewed as a transaction between the health provider and the patient, then decentralization is the process through which this transaction is brought closer to the patient. Information dissemination is about equalizing the power relationship in that transaction, so that asymmetries in information cannot lead to a skewed relationship in which the patient is not aware of whether she is receiving proper and adequate health services. Further, information dissemination is also about ensuring that the patient is now better equipped to interact with the individuals who are actually providing the health services (health providers) and the individuals who are establishing the context in which this transaction occurs (local government officials).

The aim of this chapter has been to outline the current health status of India's population and describe the structure of the health system. The argument underlying the discussion throughout this chapter has been that the failure to provide universal access to adequate health care to all of India's citizens is not a consequence of an insufficient level of resources. Rather, it is about the equality of provision of these resources, which as I stated earlier, has to do with politics more than medical care itself. The problem, therefore, is that because proper health care delivery is about politics, lack of accountability and clientelism has led to the current health situation in India. Thus, what is needed is a two-sided solution. First, the rural poor must be more knowledgeable about effective health measures and their entitlements so that they may both personally control their own health and demand their rights when they are not given them. Second, there must be an increased political will to generate pro-poor policies, which directly target the poor more so than the elites.

Information dissemination lies at the heart of both sides of this solution. For the first side, the role of information is clear: by providing information to the rural poor themselves,

they will become more knowledge about effective health measures, proper health services, and how to demand their rights from both health providers and government officials. I will develop this argument in the next three chapters. In terms of the second side of the prescribed solution, information dissemination again underlies the creation of pro-poor policies. I will discuss what constitutes a pro-poor policy, how information can help increase political will and create an environment in which these policies are created, and whether the National Rural Health Mission, a specific current Indian health program, is pro-poor in Chapters 3 and 6.

Chapter 3: Inform and Empower

The dominant paradigm regarding India's health care system has focused largely on top-down and supply-side driven solutions for improvement. Arguments rest typically on the notion that improvements in India's health outcomes will arise only in a unidirectional manner from the government to the individual, and solutions presuppose that benefits from general health policies will trickle down over time to poor individuals living largely in rural areas. However, what these canonical arguments fail to recognize is the importance of directly involving the poor as drivers of development and specifically, as active participants in strengthening their own health by demanding better health services. This, then, is the primary argument put forth in this thesis, and specifically discussed in this chapter: by providing adequate and relevant information to the rural poor about preventive health measures, about the presence of and the need to use appropriate health services, and about how to demand better health services from health providers and politicians, the poor can be empowered to control their own health and livelihoods themselves.

What contributes to the poor health outcomes of the rural poor more than the *level* of health services offered is the *distribution* of these health services. As discussed earlier, wide disparities exist not only in health outcomes between the poor and the non-poor, but also in health service use. More than 65% of public inpatient services are used by the richest 40% of the population, while only 19% of the services are used by the poorest 40% (Mahal 2001). In addition, more than 48% of public outpatient services are used by the richest 40% of the population, and 31% of the services are used by the poorest 40% (ibid). Furthermore, the poorest 20% of the population only captures about 10% of the total net public subsidy for curative services (ibid). There are two avenues through which the Indian

government can more effectively provide adequate health services to eliminate these inequalities: there must be in place a mechanism to hold government officials accountable, or the government must itself engage in pro-poor politics. Unfortunately, both of these avenues are weak, and stark inequalities persist because they are a product of a continued lack of accountability among health providers and government officials and a scarcity of pro-poor policies that focus on addressing these inequalities, both of which lead to weak public goods provision to the poor.

The aim of this chapter is to discuss how this lack of accountability and these weaknesses in public goods provision lead to the persistence of such inequalities in health outcomes and health service use. In addition, this chapter will offer a bottom-up argument as to how information about health and demanding better health services can help to improve health outcomes among the rural poor by increasing accountability of government officials and supporting an environment of pro-poor policies. The chapter is organized into two sections. The first section provides a framework for the implications of India's democracy and party politics on public goods provision, arguing that lack of information, non-credible promises made by politicians, and a weak associational life and social cleavage party politics have led to a deterioration in the provision of public goods to the poor. In addition, this section will explain why this has resulted in a paucity of pro-poor policies and has contributed to the diminished accountability of government officials. The second section articulates the main argument for how health outcomes of poor individuals living in rural areas can be improved. This section will discuss the theory that by providing individuals with information about preventive health measures, health services, and how to demand better health services, inequalities in health outcomes and health service use

can diminish. Furthermore, this section will also discuss how increased information can increase accountability and lead to pro-poor policies, concluding that the theory of information provides a bottom-up approach that can improve health outcomes in India and address inequalities both between states and between the poor and the better-off.

POLITICAL FRAMEWORK

The provision of public goods,[1] particularly health care, to the poor in India has been woefully inadequate, and has not successfully met the health challenges confronting the nation. The non-egalitarian distribution of health outcomes and health services among individuals of different incomes and ethnicities is profound, and is largely a product of clientelist policies and a lack of accountability of politicians and health providers. While it is the responsibility of India's democratic government to ensure adequate public services, including health care to its citizens, these two attributes of its political structures, clientelist policies and a lack of accountability, together have prevented equal social development in India, especially in the countryside. The question in this first section, then, is *what factors have led to clientelist policies and a lack of accountability in India, which together have resulted in inadequate public goods provision, specifically health care?*

Democracy in India has been successful despite not being an industrialized economy, having weak indicators of social development, and being home to an ethnically and linguistically heterogeneous population. At the same time, while India has witnessed rapid economic growth in the past two decades, high levels of inequality in wealth and

[1] I use public goods and public services interchangeably, having made the assumption that health care is a service that should be provided by the government to ensure that it is non-rival, non-excludable, and universal.

formidable gaps in social indicators persist, with many of these inequalities existing along class, caste, and gender lines. An intimate relationship exists between these inequalities and democracy. Ironically, democracy in India has actually contributed to many of these inequalities through an asymmetrical distribution of power and influence on policymaking, leading to clientelist policies and a lack of accountability. Moreover, social and income inequalities have challenged and undermined democracy in India due to the unequal expression of voice through the political institution and unequal ability to exert influence for individual betterment, especially for poor individuals in rural areas of India. This, too, leads to a lack of accountability for the provision of public goods. However, despite these challenges, it is precisely *through* democracy, via political action and participatory processes, that these inequalities can be erased. Not only do diminished inequalities and more political involvement by the poor contribute to a more strengthened democracy, but also, a stronger democracy can help to further diminish these social inequalities (Dreze and Sen 2002: 357).

Thus, it is particularly puzzling why in a country in which 42% of the population lives below the poverty line,[2] 71% of the population lives in rural areas,[3] and the average voter is poor, these asymmetries in power and exertion of voice continue to exist, leading to policies that still are not pro-poor and public services that still continue to fail to serve the poor, especially in rural areas. There are three primary reasons that in a democratic

[2] See World Bank, "New Global Poverty Estimates – What it Means for India." This estimate is the percentage of people living below $1.25 a day in 2005 (which, adjusted for India's PPP rate, translates to Rs 21.6 a day in urban areas and Rs 14.3 in rural areas). Based on this poverty line, the percentage of poor individuals in India decreased from 60% in 1981 to 42% in 2005. At a dollar a day poverty declined from 42% to 24% over the same period (Rs 17.2 in urban areas and Rs 11.4 in rural areas in 2005).
[3] CIA Factbook, "India." (2008)

country in which the average citizen is poor, clientelist policies and a lack of accountability still lead to the failure of public service delivery to the poor (World Development Report 2004). The first is the lack of information among the poor of the actions of politicians in terms of providing adequate and relevant public services, particularly health care, which is transaction-intensive and difficult to monitor, meaning that it is difficult to know whether correct health services are being provided. This lack of information, combined with the poor's inability for collective action, leads to weak accountability of politicians and health providers. The second reason why public services fail to serve the poor is a lack of credibility among politicians, who do not fulfill their promises of providing public services such as health care. Lack of credibility can also be combined egregiously with clientelism, leading to weak public goods provision. The third and final reason for the failure of effective public goods provision deals with the lack of associations (Chhibber 2001) and the presence of both equity politics (Bardhan in Success of India's Democracy 2001) and social cleavage based party politics in India, leading to predominantly clientelist policies.

The first of these reasons, the dissemination of information for improvement in public services, particularly health care, is perhaps the most important and when appropriately provided, the one action that undergirds all others. It provides a bottom-up solution in a context where top-down solutions have been predominantly used to address the needs of the poor, failing to actually involve them. While the need for information will be discussed more extensively in improving health outcomes later in this chapter, a brief introduction is provided here.

Despite the fact that there are more than 260 million individuals in India living in poverty,[4] the poor lack the ability to directly hold public officials accountable in providing them with basic public services such as health, because they lack information about the quality of public services and about how elected officials are involved in improving these public services. This is particularly important in the case of public services such as health care. Health, like education, is a transaction-intensive service, meaning it is dependent largely on the interaction between the client (patient) and the provider (doctor or nurse). Thus, it is difficult to gauge the quality of health care provided by clinics, and in particular, to measure the effectiveness of a public official in ensuring adequate health care is provided by clinics. Unfortunately, politicians know this, and they take advantage of this information asymmetry by transferring funds and resources to private goods for special interest groups, leading to clientelism.

Rather than a public official's track record in ensuring that doctors are providing adequate health care at clinics, what *is* visible to the voter are short-term public works projects, such as large construction projects, which even include schools and clinics (but they often soon become dilapidated due to lack of resources); provision of subsidies for basic commodities; and, promises of jobs. Giving credit to public officials for more visible and near-term actions, voters allow the politicians to continue to neglect public services such as health, at the expense of the poor.

The second reason for clientelist policies and a lack of accountability occurs in situations where even when voters have adequate information, public services still fail to reach the poor due to the fact that promises of politicians are not credible. This is because

[4] Calculated based on percentages from CIA Factbook, "India." (2007)

politicians do not fulfill promises to engage in projects that have outcomes on a long-term timeline due to office term constraints. While promises of jobs or public works projects, for example, can be delivered soon after elections, promises to improve health and education quality and outcomes are not credible as their outcomes cannot occur soon after elections. Thus, "if politicians cannot take credit for their efforts to improve teacher quality, teacher quality is likely to be low—and voters are unlikely to expect anything else (WDR 2004: 83)." The poor therefore continue to suffer from inadequate public services and policies that are not pro-poor.

Furthermore, it is often the case that clientelism combines with lack of credible promises for the majority of the poor. When politicians are credible only to specific groups of people, or their "clients," politicians then cater to the needs of these groups of people, and allocate public resources to them at the expense of health and education services to the general public. To maintain provision of public resources only to clients to whom they are credible, politicians provide more targeted, private goods to their clients rather than providing more universal, public goods that would benefit all, so as to prevent "free-riders." Subsidization of electricity in India, for example, although intended for poor farmers, often accrues to wealthy farmers in India, diverting vital resources from such services as health and education. This occurs because once political credibility becomes strongly linked to the policy of subsidization of electricity, strong interests develop around these policies by richer farmers, who then extract the benefits from the policy.

Both non-credible promises made by politicians and a lack of pertinent information about politicians' effectiveness in ensuring adequate public services contribute to the inability of the poor to act collectively through elections to advocate for their interests in

receiving better services. Thus, more bottom-up solutions are needed through which citizen initiatives can help increase accountability and improve public service delivery. In the rural context, these citizen initiatives can occur through community-based organizations, village health committees, and NGOs. Informing individuals about the importance of working together through these associations and about how to exert influence through these organizations will help enable the poor to demand better health services and to hold public officials more accountable. Unfortunately, these associations are largely lacking in India, especially in rural areas (Chhibber 2001). This leads us to the third and final reason why accountability is wanting and clientelist policies abound in these contexts.

Associations are a constitutive element of civic society and can serve as a strong complement to political institutions by engendering citizen initiatives. When used appropriately, associations have the ability to translate the voices of citizens into policies that are directed towards their needs for stronger public services. India, however, ranks very lowly in terms of percentage of its citizens who are members of an organization. In fact, while in countries such as Denmark, Norway, the Netherlands, and Sweden, over 80% of respondents belong to at least one association, in India, only 13% of respondents belonged to an association (Chhibber 2001: 17). Less than 2% of the respondents were members of caste and religious or neighborhood and peasant associations, and about 4% were members of trade unions (Chhibber 2001: 59). Furthermore, rural organizations exist in even fewer numbers. Such weakness in associational life has had strong implications for the political system in India and the provision of public goods.

The initial existence of a catchall Congress Party and the transformation of India's political system from having a dominant Congress Party after Independence in 1947 to a system with increasing numbers of political parties based on social cleavages was predicated largely on this weakness in associational life. Such low participation in associations, and thus civic life, allowed for the dominant role of the state—through the centrist Congress Party—in determining social and economic policy. In addition, the relationship is bidirectional: the continued development of such a strong state due to a weak associational structure diminished any chance of developing a stronger associational life. Thus, political parties were accorded a greater degree of power in Indian society. The stronger role of political parties and the general lack of associations became particularly salient in light of strong social divisions in India, many of which became politicized through electoral competition, leading to the decline of the Congress Party and to the rapid rise of political parties based on social cleavages, strongly influencing public goods provision because of the role of clientelist policies.

Because associations have not formed around these social divisions, predominantly based on region, religion, and caste, these social cleavages have gained traction through politicization instead (Chandra 2007). As the Congress Party has declined in power, there has been a large rise in Indian states in the number of political parties, based explicitly on these cleavages instead of issues that should be more pertinent to the lives of poor individuals, such as the provision of adequate public services. The WDP Report 2004 states, "social polarization can lead to voting based on social, ethnic, or religious identity rather than policy or service delivery performance," thereby leading to a weakened public service delivery system and a general lack of accountability. This lack of accountability is highly

prominent vis-à-vis caste, religious, and regional divisions, which are co-opted by political parties. The poor, especially, who lack education and information about adequate public services, therefore vote increasingly along these social division lines instead of policy or service delivery.

In addition, the ensuing increase in number of political parties in certain Indian states has had strong negative ramifications for public goods provision. Bueno de Mesquita (2000) argue that where the selectorate, or the winning coalition, is small, more private goods to that winning coalition will be provided at the expense of public goods for all. As the winning coalition increases in size, however, fewer private resources and a greater number of public resources will be provided so as to meet the needs of a greater number of social groups. Thus, in states where there are several viable political parties, because of a single-member simple plurality (SMSP) system, these parties need only the support of certain social groups as the winning coalition is small, and more private goods are provided. However, in Indian states with fewer political parties (such as in a two-party system), the winning coalition is much larger, and not only must more public goods be provided instead of private goods, but also, political parties must mobilize voters across social cleavages. Therefore, fewer public goods are provided in multiparty systems, and more public goods are provided in two-party systems (Chhibber and Nooruddin 2001). Thus, an increase in the number of political parties in India is correlated with a reduction in public goods provision, as resources are allocated instead to clients. This is especially salient as voters vote along social division lines instead of on policies that have to do with public service delivery.

The discussion so far has been based on the assumption that associations are simply a replacement for political parties for co-opting social cleavages. However, it would be a mistake to think that this is an exclusive definition of associations. In addition to being based on social cleavages, associations are also built around specific issues, such as improving health, and are a vital component of civic society's role in reducing poverty. With enough information on how to do so, the poor can build associations to develop coalitions that would allow them to promote pro-policies and promote greater accountability among government officials. Associations provide a bottom-up solution where top-down solutions have predominated.

The poor face a combination of a lack of information of the actions of politicians in terms of providing adequate and relevant public services, non-credible promises of public service delivery made by politicians, and the presence of a weak associational life and social cleavage-based political parties. Together, these barriers lead to a general lack of accountability and clientelist policies, and an ensuing decrease in the quality and performance of public services such as health care. While democracy should be a mechanism through which the voices of the poor are heard and adequate public services are delivered to them, asymmetry of distribution of power and lack of voice of the poor due to the factors just discussed lead to a perverted, albeit successful democracy.

The paradox of India being a successful democracy yet having deep inequalities (which threaten democracy) is explained by the fact that the interests of the powerful in society have been protected while simultaneously the weaker groups (i.e. the poor) have not been fully excluded (Kohli 2001). Kohli states:

> India's democracy has been strengthened by a political process that has facilitated a modest degree of redistribution of power and of other valued resources such as status and dignity, even if not of wealth (2).

In addition, Sen and Dreze (2002) state in India: Development and Participation:

> […] the continuation of the sharp dichotomy, with the survival of democracy, but also of the manifest economic and social inequalities, in an uneasy equilibrium (376).

Despite economic and social inequalities, democracy has been successful in India because of the accommodation of the interests of different powerful social groups. The issue, though, is that catering to the needs of these specific, multiple interest groups leads to clientelism at the expense of the poor, who cannot build an effective coalition to demand better public services. This clientelism to fit the needs of relatively powerful interest groups, which are all part of the winning coalition in specific contexts, results in a shift of public resources towards subsidies for commodities and private goods, as discussed earlier. Social expenditures are normally the first to go when this budget crunch occurs.

In addition, often times the powerful interest groups are composed of individuals who were previously severely subjugated (i.e. based on caste). These groups, when accorded power, engage in "short-run equity politics," in which reparations for a lack of dignity are sought more than improvements in livelihoods for all members of that social group (Bardhan in Success of India's Democracy 2001: 235). For instance, when a member of a low-caste group attains political power as a minister, top administrative positions are immediately transferred to members of the same caste. This occurs at the expense of the majority of members of that group (who continue to vote for leaders of their own caste),

because even in states where members of the lower caste groups (OBCs and Dalits) have entered into positions of political power, spending on public goods, particularly for the lower castes, has remained low (Weiner in Success of India's Democracy 2001). Thus, accommodation of these groups without a radical shift of resources to the poor has allowed for the success of India's democracy, but at the expense of the marginalized groups such as the poor.

This section has provided a framework to contextualize public goods provision within India's political institutions. It was argued that lack of information, non-credible promises made by politicians, and weak associational life and social-cleavage based politics have together contributed to a lack of accountability and clientelism, leading to weak public services, specifically health care, for the poor. Asymmetries in power and inequalities in ability to exert their "voice" have marginalized the poor, who have neither the information nor the ability to act collectively to demand better public services. What is needed is a mechanism through which the poor can hold public officials more accountable and build coalitions to demand pro-poor policies instead of clientelist ones. This mechanism requires both information and participatory processes, illustrated by Sen and Dreze (2002):

> As far as India is concerned, the basic problem of political marginalization of the underprivileged can hardly be solved by marginalizing them even more by further concentration of political power. The challenge, rather, is to expand the scope of democracy and address the tension identified by Ambedkar through political action and democratic practice (377).

The next section, therefore, will contextualize the previous discussion within health care. Specifically, the next section will argue for a bottom-up approach in which better

health outcomes among the poor and increased accountability among public officials and health providers can be achieved through increased health education, information about health services, and information about how to demand better health services through associations such as community based organizations. Furthermore, this section will explain how increased information is a precursor to developing pro-poor policies and utilizing participatory processes.

INFORM AND EMPOWER:

The inequalities in health service use, and the weakness in the delivery of adequate health care to the poor in India is a consequence of weak accountability mechanisms, due to which the poor can ensure neither pro-poor policies from the government nor the proper functioning of health providers. The previous section of this chapter offered an argument as to why there is a lack of accountability among politicians and a lack of pro-poor health policies in India. This section provides an argument both for how accountability can be strengthened and how pro-poor policies can be created.

Both in the academic literature and in government solutions there has been too much focus on supply-side barriers to providing the poor with relevant and adequate health care services. Likewise, as discussed in the previous chapter, solutions to the disparities in health outcomes between the poor and the better off have been predominantly top-down, and have largely not involved the poor, who are allegedly the beneficiaries of these health policies. The underlying theme here is that bottom-up, demand-driven solutions are often ignored but are strongly effective methods to providing proper health care services to the poor. This section argues that the dissemination of

various forms of information offer bottom-up solutions to the problems explained thus far: the inequalities in health care provision due to both a lack of accountability of policymakers and health care providers and a clientelist political environment, and the demand-side barriers to adequate health services.

Providing information, and more generally education, is one of the strongest methods to empowering individuals, especially those who were born into disadvantaged circumstances. Important in its own right as a human freedom (Sen 1999), what increased information and education provide individuals with is *choice* and *voice*. Individuals are empowered to access opportunities that they otherwise would have been oblivious to and to increasingly express their voice in political discourse, especially in India, where democracy theoretically provides a platform for such expression. Unfortunately, while information and education are vital to empowering the poor, corrupt politicians and those individuals with disproportionately greater resources are cognizant of this significance of information, and by hampering the poor's access to information and education, they construct a barrier to the poor escaping their situation (Weiner 1990). Thus, there is a need to increase the poor's access to information and education, with the focus here being on increased information in terms of the health service sector.

The dissemination of information to the poor is a bottom-up approach because it directly involves the poor individual herself by enabling her to improve her own health and demand better health services. Informed citizens are better able to prevent health catastrophes, take advantage of and access health services, and exercise their health rights. In addition, it is important to realize that information flow is *bi-directional*. That is, not only should information be increasingly provided to citizens, but the government must also

have constant information from the citizens about the effectiveness of programs and providers. There are three categories of information that need to be provided to the poor to improve their health status and increase their utilization of the health services. The first is information about public health measures, so as to prevent the onset of illness for the individual himself, and as a result, also for individuals around him. The second is timely information about the need for particular health services, the existence of these health services, and how to access these health services, thereby increasing the ability of poor individuals to exercise choice. The third and final category of information, perhaps the most difficult to provide, pertains to increasing the voice of the poor through increased knowledge about how to demand better health services from both politicians and health service providers when the services are lacking.

These three categories of information are relevant within two types of health services, discussed extensively in the previous chapter. The first type is public health services, which encompass population-based public services and preventive health measures. The second type is curative health services, which include both out-patient care (ambulatory care) and in-patient care. While out-patient care refers to care that can be administered at a clinic and is relatively routine, in-patient care refers to more intense care necessitating hospital admission. The distinction between these various types of health services has implications for both the types of information and the accountability mechanism framework that will be discussed here.

While the first (public health measures) and second (health services) of the three categories of information can directly result in improved health outcomes among the poor, the third category pertains to increased accountability and decreased clientelism of both

politicians and health service providers. Thus, the role of information in improving the health status of poor individuals in rural India will be discussed within the framework of accountability articulated by the World Development Report 2004. In this framework, a distinction is drawn between policymakers and health service providers, and there are two types of routes to greater accountability. The 'short' route involves the relationship between the client—in this case the poor individual—and the health care provider; in this route the aim is to increase client power so as to strengthen her clout in ensuring appropriate and adequate health services. Failure on the part of the health service provider to deliver these services to the poor individual is deemed a 'market failure,' requiring government intervention. In contrast to the 'short route', the 'long route' involves two steps. The first is called 'voice,' through which the client expresses his health preferences and demands to the government. Through the second step, 'compact,' the government communicates these client preferences to the service providers, who then provide the desired services to the clients. Failures in this route are 'government failures.'

Information asymmetries are especially egregious in various types of health services, which can be both highly transaction-intensive and discretionary, meaning that the services are hard to monitor by an external agency and the services administered change depending on each case, respectively (WDR 2004). Each type of service is relatively different in terms of how much it is transaction-intensive and discretionary, and thus, the need for various types and levels of information change depending on which service is being administered, and by whom. Failure to inform the poor individuals can lead to both market and government failures, depending on which services are being administered by whom. However, when relevant information is provided to poor individuals, both types of

health services, preventive and curative, and both routes of accountability, short and long, are strengthened. The three categories of information will therefore each be discussed within the lens of both types of services and within the framework of accountability described earlier.

Furthermore, as discussed previously, decentralization and the development of the Panchayati Raj in India has the potential to truly improve public services to the rural poor. However, success has been varied. What policymakers need to realize is that an informed and participatory citizenry undergirds the success of decentralization. Preventive measures, which are transaction-intensive and less discretionary,[5] are subject to market failures because the market does not have an incentive to provide a good that would be available to the entire public. Thus, while a decentralized government can provide these measures more effectively because it is more attuned to the public's needs, the public still needs to be informed about these measures and how to take advantage of them. In terms of public health measures, which are discretionary but less transaction-intensive, again, it is the government's role (civic society also had a large role to play here) to provide this education, and a local government can provide these services more effectively. Finally, curative services, which are both highly transaction-intensive and discretionary, are difficult to monitor, and while local governments may be more able to monitor these services, an informed public is vital for proper functioning of clinical and hospital services.

The first category of information is health education, which perhaps has the most direct effect on the health status of the poor by preventing the onset of illness before it becomes a severe problem. The role of this education is important primarily in the first of

[5] See WDP (2004), which states that population-based preventive measures can be provided by governments through outreach to the poor.

the two types of health services, as this type of information directly undergirds the success of public health services and indeed, is the basis for these types of services. Furthermore, this type of information helps the poor to escape the trap of adaptive preferences (Nussbaum 2001), whereby individuals are accustomed to poor health. In fact, poor individuals often express full satisfaction with the health services that they are receiving, perceiving them as being adequate even when in reality they are not (Banerjee 2004).

The aim of this type of health education is to promote positive changes in life styles that would actually diminish the need for health services. Individuals become autonomous producers of their own good health, as opposed to relying completely on services that will unfortunately often be inadequate. Thus, this type of information consists of education about basic measures, including:

Type of Health Education	Problem Prevented; Importance
Need for boiling water before drinking	Gastric illnesses such as diarrhea, cholera, etc.
What constitutes proper nutrition (especially for children); need for diversification of diet, including education about which types of foods provide which types of nutritional value	Stunted mental and physical growth, decreased productivity of adults
Need for bed nets and insecticides	Malaria and other diseases transmitted through insect vectors
Need for vaccinating children	Illnesses such as polio, measles, etc. This helps to prevent illness not only of the immunized child, but also other children who they interact with
Need for cleanliness and footwear (because rural households are made of dirt floors; especially necessary in areas with poor sanitation)	Long-term exposure to intestinal worms, which penetrate feet
How to ventilate homes properly when cooking	Indoor air pollution, which results in the onset of respiratory illnesses
Birth control (condoms, pills)	Unwanted pregnancies; also can lead to greater empowerment of women
Birth at an institution or with a trained worker, appropriate antenatal and postnatal practices	Infant mortalities and mother-mortalities

Sexual transmission route of HIV/AIDS and other sexually-transmitted diseases	HIV/AIDS and STIs
Effects and proper use of pesticides and fertilizers (majority of rural households engage in agricultural activities)	Toxins can accumulate in the body, leading to various illnesses, including those of the nervous system
Adequate amounts of medication	Often, health workers prescribe higher levels of medication to appease demands of clients, who equate greater amounts of medication with greater results[6]
Need for completing full course of antibiotics and other medicines	In India, prescriptions for antibiotics are assigned at disproportionately high levels, leading to the development of high resistance to diseases
Importance of population-based public health interventions	Makes such interventions more likely and more visible, thereby increasing incentives for politicians to continue to promote these kinds of interventions. Furthermore, leads to increases in compliance with various regulations

Table 3.1 *First Category of Information: Preventive Health Education*

While the previous list of health education topics is certainly not exhaustive, this first category of information does help to overcome specific demand-side barriers that were discussed in the previous section. Specifically, such health education helps obviously to overcome lack of knowledge about preventive measures (i.e. the need for boiling water, diversification of diet, insecticides/bednets, vaccinating children, and proper home ventilation). However, this information also decreases a systemic preference for curative services, which are often subpar (i.e. information about birth control and STIs). Furthermore, because changes in lifestyle due to this preventive health education lead to a decreased need for curative services, they also decrease the financial burden on rural households from utilizing these services. In addition, increased health education about

[6] Social Development Report 98. It is not clear that individuals will realize the *absence* of illness due to a particular population-based public health measure. Thus, information campaigns about the need for and the benefit of these interventions is necessary

these preventive measures and their benefits can also contribute to the overcoming of cultural norms that prevent the utilization of certain types of health services, such as contraceptive use and immunizations.

Moreover, increased knowledge about various diseases, transmission pathways, and drugs leads not only to strengthened efficacy of public health services, but also, it leads to a more empowered client in the face of curative services (i.e. knowledge about proper medications, adequate amounts of medications, and the need for completing antibiotic courses). The latter strengthens the 'short route' of accountability by increasing 'client power.' Because curative services are both highly transaction-intensive and discretionary, decreased information asymmetries are especially salient, as poor individuals can take a more active part in treatment prescribed to them by health workers and doctors. Furthermore, increased client information also informs the health workers about the particular needs of the client. Finally, the last type of health education listed in Table 3.1 pertains to increased knowledge about government-based population public health interventions. Not only does increased information result in greater 'voice' on the part of the client, thereby informing the government about their particular needs, but also, by making these services more visible to the clients, politicians have a greater incentive to provide these services since voters will see their direct effect. Thus, the 'long route' is also strengthened. Finally, mechanisms to provide this information to clients will be discussed more extensively later in this chapter and in subsequent chapters.

With this first category of information, while poor individuals may have more knowledge about preventive measures, it is fundamentally necessary that they also have increased knowledge about health problems that require particular services, about the

existence of these health services, and about how to access these health services. Lack of this type of information in large part leads to the under-utilization of health services, as illustrated by Prabhu (2001): "[…] the inability of the poor to utilize the services provided is interpreted, rather callously, as 'under-utilization' and a lack of 'demand.'" Increased information regarding these health services is a necessary step towards improved demand-driven governance. This type of health education is important in strengthening both routes of accountability and curative services in particular.

Type of Information	Importance of Particular Information
Immunization services	Household surveys show that parents often do not immunize their children against various diseases because they are not aware of the significance of vaccinations (Yazbeck 2009).
Need for an institutional birth, or a birth with a medically trained person present	Less than half of Indian mothers give birth in the presence of a medically trained person, and even fewer have an institutional birth.[7]
Antenatal Services	About half of all Indian mothers had at least 3 antenatal care visits for their last birth.[8]
Postnatal Services	Two days after giving birth only about a third of all Indian mothers received postnatal care from medically trained personnel.[9]

[7] These numbers were taken from NFHS-III (2005-2006). According to this survey, 48.8% of women give birth when assisted by a doctor/nurse/LHV/ANM/or other health personnel. The urban-rural disparity is very large, with 75.3% births in urban areas assisted by a medically trained personnel and only 39.9% births in rural areas. In addition, only 40.8% births in India are institutional, with 69.4% institutional births in urban areas and 31.1% in rural areas

[8] Of all Indian mothers, 50.7% had at least 3 antenatal care visits for their last birth; in rural areas, 42.8% of women had these visits, while in urban areas, 73.8% women did. In addition, only 18.1% of women in rural areas consumed iron-folic acid tablets for 90 days or more when they were pregnant with their last child.

[9] Of all Indian women, only 36.8% of women received postnatal care from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their last birth; in rural areas, 28.5% of women did, while in urban areas, 60.8% of women did

About the significance of contraceptives (both for men and women)	The demand for family planning services is hampered by lack of knowledge about contraceptive choices and side-effects
Community Health Fund	As part of India's new National Rural Health Mission, each Gram Panchayat is given 10,000 rupees, to be distributed to village members for their health needs; as will be discussed in the next chapter, most individuals are not aware of this fund
Health Service Schedule	Knowledge about the times that the clinic is open, the times that doctors will be present at PHCs, and the drugs available is important; admittedly, often times individuals have this knowledge, but the opening times of the clinics are inconvenient or the doctors are erratically present
Specific information about when to seek particular health services	Providing information to individuals about the need to attain specific health care in a timely manner is vital, as too often health care is delayed until the illness becomes too severe
Government health programs and schemes	Too often individuals do not know about government health programs; often times this is due to weak government implementation. If individuals knew about these programs, they could begin to demand them from the government. The next chapter will depict results from household surveys in Medak district in Andhra Pradesh

Table 3.2 *Second Category of Information: Health Services*

Studies show that lack of knowledge is a primary reason for the under utilization of the specific types of services outlined in Table 3.2. For example, mothers are often not aware of the need for institutional deliveries, antenatal care, or postnatal care, and increased maternal education is correlated with increased utilization of obstetric services (Cleland and van Ginneken 1988; Raghupathy 1996). Furthermore, contraceptive use is often hampered by lack of information about contraceptive choices and side-effects

(DeClerque et al. 1986; Donati et al. 2000). Again, while the list advanced in Table 3.2 is not exhaustive, it does offer a glimpse into how increased information about health services can increase utilization of the services and improve health status of poor individuals. More specifically, this knowledge can diminish disparities in health service use between the poor and the better off. In addition, increased information in this capacity can overcome lack of knowledge about emergency problems requiring certain health services and perhaps decrease the number of home-based births that are not attended by a medically trained professional.

Finally, for this information to further strengthen both routes of accountability, it must be combined with the third category of information, which is about how to demand better health services both from the government and health service providers. Admittedly, this type of information is perhaps the hardest both to provide to the poor and to measure. The aim of this final category of information is to enable individuals to increase accountability of both health providers and government officials and decrease clientelism so as to improve health services. More specifically, this third category consists of several different types, outlined in Table 3.3.

Type of Information	Importance of Particular Information
Budget allocation	Publicly available information of local government and health provider budgets help to increase accountability in terms of where money is being allocated.

Monitoring to assess relative effectiveness and condition of various health providers and government programs	Public performance audits with easy-to-understand information on service quality, reliability, and satisfaction help to rate quality of health providers relative to others. Constant benchmarks can help to measure improvements over time. This information should also be relayed back to government officials for evaluation purposes. (*i.e. Nepal Adolescent Project (Yazbeck 2009), Community-based monitoring in Uganda (Bjorkman and Svensson 2006), Citizen Report Cards.*[10])
Actions of government officials	Details about government programs helps to increase visibility of these programs to the voters, thereby increasing political incentive to provide these goods. This also includes photocopies of documentation from the government, and interpreters to help the poor understand the documentation.
How to directly pressure government officials, health workers, and other medically trained personnel	Through community participation and civic organizations and committees, citizens can apply public pressure on individuals to provide adequate health policies and services. Information about proper complaint and redress mechanisms is also necessary.
Need for associations	Information about how to develop and participate in civic organizations, such as NGOs, health committees, and other CBOs, is vital in collectively demanding better services and holding officials accountable.
Need for community participation and social movements	Details about the need for local organizational capacity, community involvement, and social movements in ensuring adequate health services is vital for monitoring services, pressuring providers, and building social accountability.

Table 3.3 *Third Category of Information: Demanding Accountability*

[10] PAC, Bangalore. <http://www.pacindia.org/>

Making government and health provider budget allocation publicly available and accessible can have large impacts on transparency and ensuring that funds flow to the intended beneficiaries. This is especially pertinent in Indian villages, for example, where the National Rural Health Mission mandates that 10,000 rupees, as part of the Community Health Fund, will be available to villagers from the Gram Panchayat upon request for various health needs. However, a large portion of the public is either not aware of this fund or does not demand it (Chapter 4). Furthermore, publicly available information about budgets have been shown to have an impact on accountability: "Public Expenditure Tracking Surveys in Uganda, Tanzania, Ghana, and Honduras found that asymmetric information had negative effects on the flow of funds to the local level and on service delivery. When local officials or citizens do no know their monthly entitlement, it is impossible for them to demand accountability (Narayan 2002: 34)." Because villagers often will not realistically have access to files and other paperwork, information about local budgets could also be displayed in places like public blackboards and walls, which are more visible. Ultimately, the poor are often not aware of what they are entitled to, leading to disparities in health service use and health status.

Providing individuals with information about the quality and reliability of different health service providers helps them to both monitor the providers and compare different service providers. Benchmarks help individuals to assess improvements in services provided over time. In particular, information about relative quality of curative health service providers also offers individuals choice between providers, and in addition, an increase in voice whereby they have a basis for demanding better services from the government. Thus, the 'short' route and the 'voice' segment of the 'long' route are both

strengthened. Finally, information about service quality (citizen report cards have had some success) and client satisfaction with the services is also important for government officials, who then have a basis for evaluating the services. In measuring the functioning of Essential Public Health Functions, Monica das Gupta at the World Bank (2009) states: "Little effort is made to elicit information from communities to evaluate the quality of health services, for example through surveys, from local organizations, or community meetings. Nor are evaluation results communicated to communities along with any resulting policy or program changes." However, despite the fact that individuals may have more information about the relative quality of service providers, what they still lack are accountability mechanisms to demand improved services. Information about the state of public goods, and about what rights they are entitled to, still does not enable the poor to improve their health without facilitating the use of that information (Banerjee and Duflo 2006). Indeed, what is needed is a mechanism to enable the poor to confront both local government politicians and health providers to demand both the specific types of information outlined and better health services (Jenkins and Goetz 1999).

Thus, information about how to pressure both health service providers to improve their services and government officials to strengthen the 'compact' and the 'client power' segment of the accountability framework is vital for improving health services through a bottom-up approach. Having the ability to pressure these two entities is one of the most empowering steps to ensuring adequate health services. When this information is combined with accountability mechanisms such as complaint and redress mechanisms, these two routes are strengthened and the poor can begin to actively address inadequacies in health services. However, while information about directly pressuring health providers

and government officials and about complaint mechanisms is very important in increasing accountability, this information is often not enough on its own (Banerjee et al. 2008). For this information to be effective in empowering individuals to demand better services, it must be combined with participatory action through associations and community-based organizations, which can build social capital and increase the voice of the rural poor.

The final part, then, for this bottom-up approach to improve rural health services for the poor is information about the importance of community organizations, how to build them, and how to utilize them to collectively demand and monitor health services. Collective participation through community-based organizations, or associations, not only can enable individuals to influence health provision, but social accountability and social capital also increase, which can be a goal in itself. Specifically, through associations, rural communities can directly manage local clinical services via community health centers; they can directly monitor the performance of facilities and providers (as mentioned before) through representation on a district or facility board; they can more directly participate in health promotion campaigns (many of which were discussed earlier) (Yazbeck 2009: 125); and they can more forcefully confront administrative officials, including health providers and policy makers. Furthermore, associations are particularly effective in bridging the lack of mechanisms that link communities with formal institutions such as local and state governments, increasing 'voice' and ensuring effectiveness of 'compact.' These associations enable local government officials to better understand the needs of the more vocal community. Perhaps more importantly, with individuals demanding their rights through associations, local government officials are increasingly pressured to actually use resources for the benefit of the poor. Finally, social accountability is further increased by giving

community groups more authority and control over key decisions and financial resources in community-driven projects, thereby counteracting the power of public and private providers.

These associations can take the form of community-based organizations, village health committees, NGOs, self-help groups, women's groups, youth clubs, and the Gram Sabha, which is the local government forum for political discourse. However, as surveys in the next chapter will show, knowledge of and participation in these types of organizations is very low in rural communities. Thus, increased information about the need for these organizations at the community level is vital in developing them. This information can also help to build cohesiveness and social capital within communities, which have been linked to increased voice and more effective government, especially in terms of public service provision (Putnam 1993). Further, increased social capital and cohesiveness due to this information help to overcome other barriers: for example, because transportation costs are often barriers to accessing health services, these costs for the poor can be subsidized by a community pooled fund, to which community members would contribute. Additionally, increased cohesiveness and community mobilization could help to overcome politics of shame and fear, which often prevent poor individuals from confronting government officials or health service providers to demand accountability. Finally, to reiterate what was discussed in the first section of this chapter, associations can also eventually help to decrease the politicization of social cleavages and the ensuing detrimental effects of increases in numbers of social cleavage based political parties.

Increased information also plays a role in strengthening decentralization and local governance in India. While decentralization holds the ability to improve the health care

outcomes of the rural poor through increased transparency and accountability, it still remains a supply-side approach. To be truly effective, decentralization must therefore be undergirded by mechanisms that empower the poor through information dissemination and community organization. Local governments, which are often prone to elite capture, must engage in serious changes in power structures, whereby informed communities are able to exert more voice in the political process.

The final point that remains to be addressed in terms of the need for information in strengthening health service use and health outcomes among the poor pertains to mechanisms through which this information can be relayed. One method to ensure accountability through increased information among the poor is a free press and mass media in the form of radio, television, and the internet. The influence of media has been widely recognized in India in terms of preventing famines (Sen 1999) and other abrupt catastrophes such as drops in food production and crop damage (Besley and Burgess 2002). However, while a free press and media may ensure that such sudden calamities are avoided, endemic problems in India, such as the inequalities in health outcomes between the poor and the better off, are increasingly ignored in the face of desensitization. Thus, more needs to be done to use the mass media in creating a more informed citizenry, especially poor citizens, in addition to exposing particularly heinous crimes against the poor. The media needs to reach rural areas in greater amounts by becoming more visible, however. NGOs such as CARPED, based in Hyderabad, India, engage in action research, which they then publicize through partnerships with major newspapers distributed in Andhra Pradesh and throughout India.[11] Furthermore, information dissemination does not

[11] CARPED. <www.carped.org>

occur only through the written word. Indeed, often times this is not possible, as much of the rural poor are illiterate. Therefore, mediums such as group discussions, poetry, storytelling, debates, street theater, and soap operas are equally important, especially since they can cater to all age groups. When this information *is* in the written form, social movements and specific types of NGOs can also help to translate and interpret documents and other information attained from the government.

In this section, it was argued that increased information among the rural poor in India about public health measures, about health services, and about how to demand better services provides a bottom-up approach through which accountability of health providers and government officials can be increased and clientelism can be decreased. Furthermore, associations can mobilize communities to collectively manage and demand better health services, thereby increasing social accountability and social capital. By increasing the voice of citizens to the government and their client power in the face of health providers, provision of health care can improve for the poor, diminishing inequalities in health service use and in health outcomes. Ultimately, this information is vital in not only improving the health outcomes of the poor, but also in enabling them to increasingly exert their voice in India's democracy, a substantive goal in itself.

CONCLUSION

The most fundamental argument in this chapter has been that individuals with more health information have a higher health status, and the dissemination of information is a highly salient method for empowering individuals to demand their right to adequate health care. While increased 'information' is not a panacea that can fix all health care woes, it does

underlie many of the other factors that lead to poor health service use among the poor. This information, combined with civic associations, can both increase accountability of government officials and health providers and decrease clientelism, which the first section argued were the primary reasons for the weak provision of health care to the poor. Information and associations also both undergird the development of pro-poor policies. While rigorous evidence is still needed to determine the extent of the role of information in collectively demanding better public goods, I have argued that information and participation in associations is a vital part of improving health services for the rural poor. The next chapter will discuss the evidence that has already been generated for this hypothesis, and will offer a quantitative analysis that will provide more evidence regarding the role of information and participatory action for improving health outcomes.

The participation of the poor through increased information, therefore, is central to improving demand-driven governance. While this places a greater responsibility on the citizenry to actively participate in improving their own livelihoods, it does not liberate government officials and health care providers, such as doctors, nurses, and health workers from their responsibilities of catering to the needs of the population. Both a more informed citizenry *and* increased political will is necessary to increase accountability and ensure pro-poor policies. The argument in this chapter has been that civic society and government policies should begin to take into increasing consideration the role of the poor *themselves* in ensuring pro-poor policies and fulfilling the poor's human capabilities through active political participation, free of health care woes. Thus, the next two chapters will provide both quantitative evidence for the need for increased information and results from a specific NGO's health education program. Chapter 6 will then define what a pro-poor policy

is, explain how information among the poor can ensure such policies, and evaluate whether current Indian rural health legislation is pro-poor.

Chapter 4: Health Survey in Medak

Despite India's high level of growth in the past two decades, daunting problems of poverty and inequity still persist. In regards to its health status in particular, although India has seen significant improvements in its people's health over the last fifty years, there are numerous health problems that still remain at unsatisfactory levels. Rural areas in particular face large disparities in health outcomes, as they are disproportionately subject to low public health funding, high rates of health worker absenteeism, and high rates of income poverty. Furthermore, skewed political incentives of governments lead to the provision of private and more visible benefits to some citizens, or clients, at the expense of improvements in public goods, such as health care, to the poor (Keefer and Khemani 2005).

In the previous chapter I argued that this lack of public goods provision, particularly health services, is due to clientelism and a lack of accountability of government officials and health providers, leading to wide disparities in health outcomes and health service use between the poor and the better off. Solutions have been predominantly top-down, and have continued to operate *through* a bureaucracy that neglects the poor. In a democracy where the poor are increasingly marginalized and have little voice, then, a bottom-up approach is needed in which information and participation in community-based organizations can lead to demand-driven governance and improved health services. In terms of health care, this information is of three types: information about preventive health measures; information about the need for and the existence of particular health services; and information about how to demand better health services from both government officials and health providers. Increased information, when combined with participatory action through community-based organizations, can enable the poor to pressure

administrative officials into improving the delivery of health services, strengthening both the long route and the short route of accountability outlined by the World Development Report 2004.

Furthermore, although the third type of information—about how to demand better health services—is difficult to measure, it can help to increase accountability of both government officials and health providers. Where accountability mechanisms are weak, the poor are unable to interact or influence health providers or the state (other than voting, which is frequently not based on policy platforms (Chandra 2007)). Where there is dissatisfaction with and complaints about government health programs, the poor have no alternative (Saxena 2004; Mehta 2003). Therefore, the third type of information is especially salient—helping individuals understand what they are entitled to—although it must actually be through direct interaction and even confrontation with health providers and government officials to demand their rights to adequate health (Jenkins and Goetz 1999). Furthermore, as discussed in the previous chapter, when combined with community-based action through associations, the poor can more effectively pressure administrative officials to improve the status of health care in their communities. While the first two types of information can directly influence health outcomes and health service use, the effect of the third type of information is much more difficult to measure and examine.

Rigorous evidence has recently begun to emerge, however, to explore the effect of increased information and community-based participatory action on improving the state of public goods in rural areas of developing nations. In this chapter I argue based on results from a health survey administered to 122 individuals in 6 different villages in the Medak

district of Andhra Pradesh, that increased information and knowledge about government programs can lead to increased interaction with administrative officials.[1] Knowledge about particular government health programs, and knowledge about what they are entitled to, is the first step for poor individuals living in rural areas to begin to demand better services from both government officials and health providers. The second step, of course, is actually interacting with both government and health officials, so that these individuals may demand documentation and information to confirm whether they have received what they are entitled to. Therefore, the second hypothesis in this chapter is that increased membership in associations can lead to increased interaction with administrative officials as well. In addition, this chapter also addresses the following questions:

1. Because it is through direct confrontation with health providers and local politicians that individuals can begin to demand better health services, *what additional factors lead to increased interaction with administrative officials?*
2. *What factors lead to increased participation in associations and the Gram Sabha in the first place, through which the community can collectively improve the state of health services?*
3. *What specific factors lead to increased knowledge about health programs and policies?*

This chapter is organized into five sections. It begins with a review of the literature and evidence regarding the role of information and participatory action in improving the status of public goods, specifically health services, in rural communities and particularly in India. The subsequent section will describe the status of health outcomes in the Medak district

[1] I use the term "administrative officials" in order to encompass both government officials and health workers.

and in Andhra Pradesh, where this survey was administered. This section will also explain the methodology used in administering these surveys. The third section explains the research design employed in this study, including the logic behind the specific regression models and a description of the variables used. The fourth section develops a framework of the health status and health facility use in these villages, provides evidence for the primary argument, and addresses the questions posed earlier. The final section concludes with a discussion of the findings and the ensuing implications.

LITERATURE REVIEW

Explanations for poor health outcomes among India's poor center on public health underfunding by the government and low income among the poor. While these reasons are clearly very important as areas of focus for policies, they do not fully explain the disparities in health outcomes and health service use between the poor and the better off, and between states. More important than the level of public health funding is the distribution of funding (Prabhu 2001). Increased income alone cannot lead to better health outcomes (ibid). Furthermore, what these two explanations, in addition to that of the benefits of decentralization, do not fully recognize is the role of information and participation among the beneficiaries of the health services, particularly in rural areas.

Recent research has begun to illuminate the importance of information in improving health outcomes among the poor. Enson and Cooper (2004) discuss demand-side barriers to receiving proper health services, arguing that increased education and information about the need for health treatment, about where to receive treatment, and about what constitutes proper treatment can help to eliminate disparities in outcomes and health

service use. I discussed these types of information in the previous chapter, highlighting their specific significance. Deepa Narayan (2002), however, talks more generally about the need for information in improving service delivery:

> Informed citizens are better equipped to take advantage of opportunities, access services, exercise their rights, negotiate effectively, and hold state and non-state actors accountable. Without information that is relevant, timely, and presented in forms that can be understood, it is impossible for poor people to take effective action (19).

Jenkins and Goetz (1999) also point to the need for information, but they discuss it specifically in the context of demanding information from government officials about their operations. They stress the need for interaction with administrative officials to not only demand more information, but also to demand accountability. Thus, Jenkins and Goetz consolidate the notions of increased information and increased participatory action. Furthermore, Ruth Alsop, et al., through a study of 53 villages in Rajasthan and Madhya Pradesh, India show that increased education and increased information are both positively correlated with increased participation in the Gram Panchayat, which is the local government in India.[2]

Additionally, randomized trials are now increasingly being used to understand the effects of interventions to both increase information about service delivery and facilitate interaction among individuals living in villages and interaction between these individuals and administrative officials. Results from these studies have been mixed, however, necessitating more evidence. Abhijit Banerjee, et al. (2008) conclude that simply giving villagers information about the state of public goods in the village, without facilitating the

[2] Social Development Paper 37, World Bank

use of that information, may not always be very useful. Results from their interventions to increase information and participation through the Village Education Committee did not have an impact on community involvement in public schools, and had no impact on teacher effort or learning outcomes in those schools. On the other hand, Bjorkman and Svesson (2006) conclude positive results from an intervention in Uganda to encourage community-based monitoring of health care service delivery. Communities were more involved in monitoring the provider and the health workers appeared to exert higher effort to serve the community. There were also large increases in service utilization and improved health outcomes, including reduced child mortality and increased child weight.

One of the main differences between these two studies was that the health clinics in Uganda were more visible than the schools in Uttar Pradesh, where the former study was performed. An additional difference was that the CBOs that facilitated the intervention in Uganda seemed to have played a much more active role in pressuring public providers to improve performance than the CBO in the India study, involving the elites in the village more so in the Uganda study. Thus, it seems that interaction with administrative officials in a village is needed for improved health services. In addition, CBOs can help to facilitate this interaction. In fact, Jenkins and Goetz (1999) state, "It is hard to see how people's knowledge can translate into power without critical engagements with the bureaucracy, or exposure and prosecution of corrupt practices-all supported by a social movement to protect the poor from the inevitable backlash (610)."

This chapter, therefore, focuses on the factors that explain variation in interaction with both local government officials and health providers in or near the villages. The main argument is that increased knowledge about government programs *does* lead to increased

interaction with these administrative officials. These explanatory factors include not only increased knowledge about programs and increased education, but also the presence of serious health problems, membership in community-based organizations, and perceptions of the local governments. Furthermore, this study also identifies those factors that lead to increased membership in associations and increased knowledge about government health programs. Identifying factors that lead to increased interaction with administrative officials in Indian villages is vital, as it provides evidence on which to build specific policies to address the disparities in health outcomes in India.

DATA COLLECTION

The survey on which this study is based was administered in the Medak District of Andhra Pradesh, a southern state in India, between July and September 2009, with the help of CARPED (Center for Action Research and People's Development), an NGO based in Hyderabad. Although Andhra Pradesh (AP) in particular was chosen because of personal connections and ease of personal travel, the state provides a representative sample among the different states in India. AP is considered to be part of the "early to middle transition" and "low to moderate capacity" category, signifying that it still faces substantive patterns of ill health from malnutrition and communicable disease, and that its institutional capacity still remains low. Furthermore, AP has similar averages to India as a whole in terms of health indicators, such as life expectancy at birth, neonatal mortality, and infant mortality.[3]

[3] See Better Health Systems for India's Poor. Life expectancy at birth average: 62 years in AP vs. 61 years in India as a whole; Neonatal Mortality: 44 deaths per 1,000 live births vs. 43 in India; Infant Mortality Rate: 66 deaths per 1,000 live births vs. 72 in India.

Thus, observations and lessons drawn from AP can be applicable to other areas of India as well, albeit admittedly with some caution.

The Medak district in AP was chosen not only because that is where CARPED—the NGO with whom I administered the surveys—primarily operates, but also because it is one of the most underdeveloped districts in AP. Agriculture is the occupation of 80% of the main workers, and half (49.2%) of the district's population lives below the poverty line, whereas 22.2% of individuals in AP as a whole live below the poverty line. Furthermore, the female literacy rate in Medak is 19.3% while the average for AP is 32.7%.[4] Because Medak is more underdeveloped than most other districts in AP, if anything, results will provide an *overestimate* of the seriousness of the current situation in AP, which is much more acceptable than an underestimate of the situation. Finally, within Medak the Kowdipally mandal was selected because that is where CARPED focuses its efforts. Many of the villages in Kowdipally are home to significant populations of Lambadas, individuals who are considered as part of the lowest rung of the caste system.

The survey was administered to approximately 20 households in 6 villages each for a total of 122 surveys. Villages were selected in pairs according to similar approximate distance from a primary health clinic (PHC) and similar household numbers. Two of the villages were tribal hamlets with significant Lambada populations. Sadashivapally (98 households) and Pampally (75 households) are both 6 kilometers from a PHC; Kannaram (120 households) and Mahommadnagar Gate Thanda (59 households) are 3.5 kilometers and 1.5 kilometers from a PHC, respectively; Bhattu Thanda (38 households) and Antharam

[4] CARPED. <www.carped.org>

(146 households) are 23 kilometers and 11 kilometers from a PHC, respectively. Both Bhattu Thanda and Mahommadnagar Gate Thanda have significant tribal populations.

In terms of the administration of the survey itself, the households in each village were selected by dividing the total number of households by 20. In Antharam, for example, which has 146 households, every 7th household was selected to survey. Each survey was conducted with the male or female head of the household, alternating between males and females in each successive household to depict a more complete picture. Finally, the survey instrument contained questions about demographics, recent individual health status, utilization of public versus private health facilities, meetings with administrative officials, knowledge of government health programs, participation in community based organizations, and perception of the local government.

RESEARCH DESIGN:

Actively meeting with both local health providers and local government officials is a vital step to demanding better health services and policies via increased social accountability. The argument here is that increased information among individuals about government health programs *and* increased participation in associations leads to increased interaction with both health providers and government officials. The first hypothesis is that increased knowledge among individuals will lead to increased meetings with health providers and government officials. The second hypothesis is that increased membership in associations leads to increased meetings with health providers and government officials. I test these hypotheses with two models, which differ by whom the meetings are with: government officials or health providers. In the first model the number of meetings with

health providers is the dependent variable. Respondents were asked whether they had ever tried to meet each of four different individuals who constitute the health provider category. The dependent variable for health providers was then recoded into a combined dummy variable in which 1 signifies that the respondent has met with *any* of the different individuals, and 0 signifies that the respondent has never met with any of the four individuals.

The four different types of health providers are individuals who are assigned a prominent role in providing health services to individuals in the villages, including: the PHC (primary health clinic)-in-charge, auxiliary nurse midwives (ANM), ASHA workers, and Anganwadi workers. The PHC-in-charge is the medical officer who supervises operations of the PHC.[5] ANMs are the health providers closest to the community, and are found at the village sub-centers. Their role is to visit a few villages in their domain to provide services, give medicines, and supply advice to men, women, and children. As part of the National Rural Health Mission (NRHM), ASHA workers are trained to work as an interface between the community and the public health system and they are from the very villages where they work. Finally, Angawadi workers work at Anganwadi centers, which are government-sponsored child and mother care centers. Anganwadi workers are chosen from the communities themselves and are given training in health, nutrition, and child-care.

In the second model, the dependent variable is the number of meetings with local public officials, who I call policymakers. Similar to the first model, here too, respondents were asked whether they had ever tried to meet each of three different individuals who constitute the policymaker category. The dependent variable for policymakers was also

[5] Indian Public Health Standards (IPHS) For Primary Health Centres. <http://mohfw.nic.in/NRHM/Documents/IPHS_for_PHC.pdf>

recoded into a combined dummy variable in which 1 signifies that the respondent has met with at least one of those three different individuals, and 0 signifies that the respondent has never met with any of the three individuals. The three different types of policymakers are individuals who have a large role in the affairs of the village, and are all government workers: the Sarpanch, Collector/District Magistrate, and District Health and Medical Officer (DHMO). The Sarpanch is a democratically elected head of the village level of the Panchayat Raj system. The Collector is the head of the Zilla Prashad, which is the district level of the Panchayat Raj establishment. Finally, the DHMO is responsible for implementing the National Health Programs and comes under the Zilla Prashad.

The first primary independent variable in both models is knowledge about government health programs and policies. The Health and Nutrition Poverty Reduction Strategy Papers state, "Human assets in the household—knowledge, literacy, and education—are also important, especially about health issues: lack of such knowledge, which is especially common in poor households, often leaves members of the household unaware of available healthcare opportunities (11)."[6] Thus, the knowledge variable is a measure of whether individuals are aware of the health programs that they are entitled to; knowledge of these entitlements is a first step towards interacting with health providers and policymakers to begin to demand better health services, and therefore, there should be a positive relationship between knowledge and meetings with health providers and policymakers. To construct this measure, respondents were asked if they had ever heard of each of seven different government health programs or policies. Knowledge was then recoded as an ordinal variable measuring whether individuals had heard of 0, 1-2, 3-4, or 5-

[6] Health, Nutrition, and Population Strategy Papers. World Bank.

6 programs and/or policies. These programs and policies included: Right to Information (RTI) Act, National Rural Health Mission (NRHM), Community Health Fund, National TB Control Program (NTBCP), DOTS Program, Pulse Polio, and Arogyasri.

The RTI Act was passed in 2005 and ensures individuals the right to any information pertaining to government affairs. The NRHM was also launched in 2005, and aims at improving basic health care service delivery to rural India. The Community Health Fund is part of the NRHM and ensures 10,000 rupees annually to Gram Panchayats for the community's health needs. The NTBC Program has been in existence since 1962, while the DOTS (Directly Observed Treatment Short course) Program was launched in 1997 as part of the Revised NTBC Program. Pulse POLIO was launched by the Indian government in 1994, and has been successful in dramatically reducing the prevalence of polio in India. Finally, Arogyasri is a community health program launched in Andhra Pradesh in 2007, providing financial protection (up to 2 lakhs per year) to families living below the poverty line for treatment of serious ailments requiring hospitalization and surgery.

The second primary independent variable is participation in associations, which is an interval variable constructed by asking respondents how many of the following associations they currently participate in: traditional village committees, village health committees, caste committees, religious committees, women's cooperatives, NGO groups, and youth clubs. Information about entitlements without mechanisms to utilize that information is often not very effective. As I argued in the previous chapter, associations enable community participation by not only building social capital but also by supplying a mechanism for collectively applying pressure on administrative officials to increase accountability. Therefore, I expect a positive relationship between participation in

associations and interaction with administrative officials. Of the different types of associations included in the survey, perhaps the most relevant is the village health committee, the functioning of which has been encouraged by the NRHM. The VHC is intended to be a part of the local self-governance structure of the Panchayati Raj, and specifically part of the Gram Sabha. The purpose of the VHCs is to build and maintain accountability mechanisms for community-level health and nutrition services provided by the Government.[7] Thus, not only are VHCs examples of associations that can enable collective action, but also, by virtue of their purpose, they are especially well situated to facilitate interaction with health providers and government officials to ensure adequate health services.

The third independent variable is a dummy variable measuring the frequency of respondents who indicated that they attended the most recent Gram Sabha. The Gram Sabha is a vital mechanism for the dissemination of information to individuals in villages because at this forum the Gram Panchayat presents the annual statement of accounts, reports from the previous financial year, the last audit note, and the development plan for the coming year, providing a platform for widespread transparency and accountability.[8] Here, too, I expect a positive relationship between participation in the Gram Sabha and interaction with administrative officials.

A final independent variable included is the presence of an individual serious health problem. Respondents were asked if they had experienced any of 27 health problems in the previous 30 days. Respondents were also asked if they had ever had tuberculosis or any of

[7] Vistaar Project: Role of Village Health Committees in Improving Health and Nutrition Outcomes: A Review of Evidence from India. < http://www.intrahealth.org/page/vistaar-project>
[8] Social Development Paper 37

four different types of surgeries. Because serious health problems are relatively infrequent, these responses were combined into one dummy variable, with 1 signifying that the individual had either experienced at least one serious health problem in the previous 30 days or had had surgery at some point in her life. A 0 signified that the individual had had neither a serious health problem nor surgery. This variable tests the hypothesis that increased health problems can lead individuals to interact with health providers and government officials to ensure proper health care.

One political perception control was included in the model. Respondents were asked how corrupt or honest they thought the Sarpanch was, and responses were included as an ordinal variable with increasing values signifying less perceived corruptness. A set of individual-level control variables was also included in each regression model to take into account alternative explanations for increased meetings both with health providers and policymakers. Four demographic variables are included that could potentially influence whether individuals meet with administrative officials in or near their villages. Age is an important control as younger individuals are more likely to meet with the specific health providers included in the survey, since they will have likely have young children. In addition, gender was included as a control variable, as women are often less likely to meet with policymakers and participate in public organizations (Basu 1992; Ray 1999). Education level is also a large determinant as increased education leads to a heightened ability to understand the various mechanisms to apply pressure on village health providers and government officials. Finally, number of children was also included, as households with a greater number of children are likely to meet more with health providers and be aware of government health programs that specifically pertain to the health of their children.

Information and knowledge among individuals about what they are entitled to empowers them to directly interact with health providers and government officials. Participation in associations and the Gram Sabha (GS) facilitates this interaction and provides a mechanism to further empower individuals to ensure accountability from these administrative officials. The question, then, is *what factors lead to increased participation in associations and in the GS?* I develop two models to explain the variation in participation in associations and in the GS. In the first regression model the dependent variable is an interval level variable measuring participation in associations. In the second regression model the dependent variable is a dummy variable measuring participation in the most recent GS. In each model four demographic individual-level variables are included: age, gender, education level, and number of children. Females are likely to participate in the GS and associations less frequently.[9] I posit that increased education will lead to increased levels of participation in associations and especially in the Gram Sabha, as individuals will understand better the importance of participation in both entities. Furthermore, two participation variables are included: meetings with health providers and policymakers. In addition, a variable measuring whether the respondent had experienced a serious health problem is included. Finally, a variable measuring knowledge about government health programs is included in the model to help explain in part the variation in participation in associations and the Gram Sabha.

Thus, there have been two sets of regressions estimated in this chapter: the first is based on the hypotheses that increased knowledge about government health programs and

[9] Anecdotal evidence from where these surveys were administered suggests that women consider the political arena (Gram Sabha, interaction with government officials, etc.) to be the domain of men.

increased associational life will lead to increased interaction with administrative officials; the second explains the variation in participation associations and the GS. A fundamental question remains, however. *What leads to this knowledge in the first place? What factors explain the variation in knowledge among individuals about the government health programs that they are entitled to?* A regression model with knowledge as the dependent variable is constructed to answer this question. The same four demographic individual-level variables as before are included: age, gender, education level, and number of children. Four participation variables are included: meetings with health providers, meetings with policymakers, participation in associations, and attendance at the last GS to assess whether increased participation and interaction with administrative officials has a bidirectional relationship, causing an increase in knowledge. Finally, the presence of individual serious health problems is included in this model as well, to determine if health problems lead an individual to seek more information about relevant government programs.

RESULTS

An understanding of the health facility utilization landscape in these villages is an important first step to analyzing the results of the models developed in this chapter. When asked where their most recent visit to a health care facility was, respondents overwhelmingly visited a private health facility instead of public facility, as illustrated in Table 4.1. The majority of respondents visited either a private hospital or a registered medical practitioner during their most recent visit to a health facility, both of which often leads to deleterious consequences: private hospitals are expensive, placing a large financial

burden on households (Peters et al. 2002), and RMPs are often not trained at all, or are under qualified (Kumar et al. 2007).

	Frequency	Percent
CHC/PHC	8	6.56
Gov. Referral Hospital	3	2.46
Private Hospital	49	40.16
Private Qualified Doctor	4	3.28
Private Compounder/Nurse	2	1.64
Registered Medical Practitioner (RMP)	56	45.90

Table 4.1 *Frequency of Facility Usage (122 Respondents)*
Original data collected by author

Furthermore, of those respondents who visited a private facility, the majority of respondents cited reasons pertaining to lack of both adequate facilities and proper care (see Table 4.2).

	Frequency	Percent
Doctors and staff not available/absent	96	.87
Quality of treatment not good	101	.91
Lack of facilities (medicines, beds, equip.)	31	.28
Alternative medical care was closer	3	.03
Alternate care was affordable/free of cost	2	.02
Staff not attentive or caring	47	.42
Previous experiences not good	34	.31
Medical emergency	11	.10
Other	11	.10

Table 4.2 *Why didn't go to a Government Facility (111 Respondents)*
Original data collected by author

Reasons for why these respondents visited private facilities instead of government facilities were consistent, with the majority of respondents again citing reasons pertaining to adequate facilities and proper care (See Table 4.3).

	Frequency	Percent
Doctors and staff available	95	.86
Quality of treatment was good	99	.89
Good facilities (medicines, beds, equip.)	35	.32
Close geographically	39	.35
Affordable/Free of cost	6	.05
Attentive and caring staff	66	.59

Previous experience was good	24	.22
Medical emergency	1	.01

Table 4.3 *Why Went to a Private Facility (111 Respondents)*
Original data collected by author

The reasons why individuals do not visit government facilities align with results from many of the surveys administered to understand the deficiencies of India's rural health care system.[10] The majority of these reasons pertain to doctor absenteeism, poor quality of treatment, and inattentive and rude staff. All of these reasons can be subject to improvement through increased interaction with health providers and policymakers, if the interaction rests on community-wide pressure on these administrative officials to ensure that doctors are available and that the facility staff provides proper treatment and treats the poor patients with respect.

Thus, with this understanding, an initial crosstabs measuring the effect of knowledge on interaction with health providers and policymakers confirms the hypothesis that increased knowledge about health entitlements leads to increased interaction with both categories of administrative officials (See Tables 4.4 and 4.5). In both tabulations, the calculated chi-squared values are significant at the conventional $\alpha = .05$ level. There is a clear relationship in both sets of tests: as knowledge of programs increased from 0 to 5-6, individuals who claimed that they visited a health provider increased from 0 percent to 100 percent; in terms of interaction with policymakers, as knowledge of programs increased from 0 to 5-6, individuals who claimed that they met with a government official increased from 0 percent to 100 percent.

Knowledge of Programs	Health Provider	
	No	Yes
0	100.0	0.0

[10] Ministry of Health and Family Welfare. <http://www.mohfw.nic.in>

1-2	70.1	29.9
3-4	33.3	66.7
5-6	0.0	100.0
Total	67.5	32.5
Pearson $\chi^2(3) = 15.18$	Pr = 0.002	

Table 4.4 *Knowledge vs. Health Provider*

Knowledge of Programs	Policy Maker	
	No	Yes
0	87.5	12.5
1-2	76.3	23.7
3-4	33.3	66.7
5-6	33.3	66.7
Total	72.7	27.4
Pearson $\chi^2(3) = 10.87$	Pr = 0.012	

Table 4.5 *Knowledge vs. Policy Maker*

Data from the two initial regression models directly testing the hypothesis that increased knowledge can lead to increased interaction with administrative officials confirms my primary hypothesis. Regression results show that there is both a substantive and highly significant positive relationship between knowledge about government health programs and interaction with both health providers and policymakers. In addition, the presence of a serious health problem in the previous thirty days and/or surgery is also highly positively correlated with interaction with health providers and policymakers. While this is perhaps expected in terms of meetings with health providers, the fact that there is also more interaction with government officials suggests that individuals perhaps perceive meetings with government officials to be beneficial in improving their health status.

Independent Variable	Health Provider	Policy Maker	Associations	Gram Sabha	Knowledge
Demographics					
Age	-0.06	-0.01	-0.02	0.05	-0.01
	(0.02)**	(0.02)	(0.06)	(0.02)**	(0.03)
Female	-0.03	-0.34	0.89	-0.26	0.14
	(0.10)	(0.08)***	(0.21)***	(.09)***	(0.14)
Education Level	0.10	0.04	0.15	-0.01	0.01
	(0.04)***	(0.03)	(0.12)	(0.04)	(0.07)
Number of Children	-0.06	-0.00	0.06	-0.01	0.07
	(0.03)**	(0.02)	(0.07)	(0.03)	(0.03)**
Health					
Serious Health Problems	0.20	0.26	0.04	-0.01	-0.15
	(0.09)**	(0.07)***	(0.22)	(0.09)	(0.13)
Knowledge	0.28	0.15	0.18	0.14	
	(0.06)***	(0.07)**	(0.16)	(0.08)*	
Perception					
Sarpanch Honest	0.15	0.22			
	(0.05)***	(0.04)***			
Participation					
Health Provider			0.09	-0.01	0.37
			(0.22)	(0.08)	(0.13)***
Policy Maker			0.58	0.16	0.18
			(0.24)**	(0.10)*	(0.12)
Associations	0.02	0.08			0.04
	(0.04)	(0.04)**			(0.04)
Gram Sabha	-0.02	0.12			0.19
	(0.08)	(0.08)			(0.12)
Constant	-0.24	-0.25	-0.47	0.36	0.52
	(0.20)	(0.16)	(0.32)	(0.19)*	(0.25)**
Number of Observations	117	117	117	117	117
R^2	0.37	0.32	0.26	0.37	0.45

Table 4.6 *Interaction with Administrative Officials, Participation in CBOs, and Knowledge*[11]
Note: Robust standard errors are reported.
*$p < .10$. **$p < .05$. ***$p < .01$

[11] To ensure the accuracy of these models, several different diagnostics were performed. To confirm that there is no multicollinearity, variance inflation factors were generated: VIF = 1.46, eliminating worries of multicollinearity. In addition, Whites General Test showed positive results for heteroskedasticity only for some models, but robust standard errors were used in all models. Finally, df-Beta and Cook's D statistics were calculated to identify 5 outliers. All regression results are derived from data in which these 5 outliers were removed.

Furthermore, while participation in associations did not have a significant relationship with meetings with health providers, there was a significant positive relationship with meetings with government officials. Although this result is as expected for policymakers, but not health providers, it does make intuitive sense because of the nature of the associations that were included in the survey questions (except for the Village Health Committee). Because the associations were based more on social cleavages and political advocacy, it is understandable that participation in associations leads to greater interaction with government officials. This confirms our second hypothesis.

Increased perceived honesty of the Sarpanch had a substantive and highly significant positive relationship with interaction with both health providers and policymakers. If individuals think that the Sarpanch is honest, they will more likely interact with her with the hope that she will actually work for their benefit. As expected, increased education level was correlated with increased interaction with health providers, suggesting that more educated individuals understand better the need to interact with health providers. Interestingly, however, increased education did not have a significant positive relationship with interaction with government officials. In addition, age had a negative relationship with interaction with health providers, most likely because younger individuals are more likely to have young children, for whom meetings with health providers is more necessary. Age was not a significant variable in terms of interaction with policymakers. Finally, while there is no relationship between gender and interaction with health providers, there is a strong negative relationship between being female and interaction with government officials, which confirms anecdotal evidence from these surveys. Women interact less with government officials, which is a point of concern.

There are two further questions that need to be addressed. First, *what factors lead to increased participation in associations and the GS?* Second, *what factors lead to increased knowledge about government health programs?* To answer the first question, two regression models were developed with participation in associations and in the GS as dependent variables. In these models, very few explanatory variables were significant. Women are more likely to participate in associations, which is surprising. However, this makes sense when we observe that the result is driven by the fact that women participate heavily in self-help groups. Thus, these self-help groups, or women's cooperatives, could be a specific type of association through which interventions can function to empower individuals to begin to meet with government officials. In addition, there is a positive relationship between meeting with policymakers and participating in organizations Finally, knowledge about government health programs did not have a significant relationship between participation in associations or the Gram Sabha at the conventional $\alpha = .05$ level (although knowledge was significant for participation in the GS at the $\alpha = .10$ level).

To answer the second question, a final regression model was constructed with knowledge about government health programs as the dependent variable. Again, very few of the explanatory variables were significant. Number of children had a positive relationship with knowledge, which can be attributed to the fact that several of the health programs have to do with children's health. The only other significant positive relationship was between having met with a health provider and knowledge. Thus, there is a bidirectional relationship between knowledge and interaction with a health provider: meeting with health providers helps to increase information about government programs,

and increased knowledge about health entitlements leads to increased meetings with health providers. Both of these can lead to better health outcomes.

DISCUSSION AND IMPLICATIONS

In this chapter I presented an argument for what leads to variation in interaction with health providers and government officials in rural India. The argument focused on the role of information about health entitlements and participation in rural associations in increasing meetings with these individuals. To summarize, two regression models were estimated to confirm two hypotheses: first, that increased knowledge about health programs is important in increasing interaction with officials and second, that increased participation in associations is important in increasing interaction with government officials. Furthermore, three additional regression models were estimated to identify factors that lead to increased participation in associations and increased knowledge.

While I discuss three types of information that are particularly salient in improving health outcomes among the rural poor, perhaps the most important in ensuring that the health system begins to change is information that empowers individuals to directly pressure health providers and governments to improve health services, especially in an environment that is clientelist and lacks adequate accountability mechanisms. In these villages in Medak in particular, schools and health facilities do not function effectively. CARPED, the NGO with whom this work was conducted has launched initiatives to promote community sensitization and mobilization to address these issues. Through their work, the communities have started demanding better services, and immunization rates have also improved significantly over the past few years.

What is needed, therefore, is sustained effort throughout Indian states on increasing knowledge about health entitlements and encouraging associational membership, as the combination of the two constitute a bottom-up approach to improving India's health systems. While the mechanism through which information and participation are effective at reducing disparities in health outcomes between the poor and the better off was discussed in Chapter 3, the basic intuition is that increased knowledge can lead to increased interaction with health providers and government officials. This information strengthens both routes of the accountability framework put forth by the World Development Report 2004, and while information alone cannot solve all the problems of India's health systems, it does play a large and hitherto disproportionately ignored role in doing so.

While the results of this chapter showed significant results in the relationship between knowledge, association membership, and interaction with administrative officials, this is only a first step in understanding the relationship between these three factors, and there are several directions for future research. First, this study did not delve into the nature of the interaction between individuals and health providers and government officials, which can provide valuable insight into how increased interaction actually leads to improved health outcomes. Second, this study did not explore the varied effects of participation in different types of associations, some of which are more politically relevant than others. Finally, future research should also take into account the different types of health programs, as knowledge of specific health programs can lead to varying effects on interaction with officials. Ultimately, however, the evidence and the arguments advanced in this chapter are relevant only when directly applied through organizations on the ground in India, which I discuss in the next chapter.

Chapter 5: Partnerships on the Ground

Effective health programs in India based on prevention are scant, as the system rests largely on curative services. Through a prevention-based health system, costs can be restrained and the health of the population can be improved. To develop this prevention-based health system, health education for the individuals living in the communities is vital. In addition, in order for India's health systems to improve as a whole, the government needs to look more aggressively for opportunities to build transparent partnerships with the private sector and civil society in order to address the needs of rural communities.

As I argued in Chapter 3, there are three types of information that can help to reduce disparities in health outcomes and health service use between the poor and the better off, and preventive health education is the first type. The second is timely information about the need for particular health services, the existence of these services, and how to access these services. The third and final category of information pertains to increasing the voice of the poor through increased knowledge about how to demand better health services from both politicians and health service providers when the services are lacking.

With its Health Educator-Leader Program, Healing Fields Foundation (HFF), a non-profit organization based out of Hyderabad, India, endeavors to address the lacuna of health knowledge amongst the individuals living in these impoverished communities by focusing on provision of the first two types of information. In fact, HFF provides education regarding every topic listed in Tables 3.1 and 3.2. By training individuals from the communities themselves, HFF also hopes that the health leader will become the point of contact for any health needs of the community. Furthermore, through health sessions led by the health leaders, the community members themselves will gain knowledge about

better health practices and will become empowered to take a more active role in their own health. Finally, Healing Fields provides a highly promising partner for the government in developing a more bottom-up solution to the challenges facing India's health systems.

OVERVIEW

Healing Fields Foundation's training program for developing health leaders-educators is based largely on collaboration with various entities, including other NGOs, the private sector, and the government. The mission of the program is to build health champions who will serve as health educators in grassroots communities to be advocates for the community and to be agents of social change. In its work it aims to fulfill the following objectives:

1. To create awareness on general health, nutrition, sanitation, personal and environmental hygiene, and diseases in order to design and implement preventive programs of health.
2. To create awareness on how to identify and implement processes that can work to improve accessibility of healthcare to people.
3. To develop and strengthen linkages for social development through building health leaders/champions.
4. To develop, apply, and disseminate knowledge about healthcare delivery systems and services, their organization, and management.
5. To disseminate knowledge of different government health programs and to build linkages with government agencies working in the health sector.

6. To develop and implement health education at the grassroots level to prevent illnesses, epidemics, and access to quality healthcare.

Having finished its second batch of health educator training in August 2009, Healing Fields Foundation's program trained a total of 26 health educators from 23 separate communities covering 11 mandals over 4 different districts in Andhra Pradesh. HFF is currently operating in Hyderabad, Secunderabad, Warangal, and Rangareddy and is looking to expand into several more areas in its forthcoming training batch.

Selection of whom to train from the communities is based on a certain set of eligibility criteria, shown in Table 5.1.

Criteria	Requirement
Background	SHG leaders/members, Community Volunteers, NGO/MFI staff
Education	Minimum 9th Standard (grade) (Should be able to read and write in regional language)
Age	Above 18 years
Gender	Male or female, but females have more influence in healthcare decisions
Skills	Communication, good standing within the community
Motivation	Personal ambition, healthcare interest, recognition

Table 5.1 *Eligibility Criteria*

Once selected, participants of the health education attend training sessions once a month for 6 consecutive months, each session lasting for 4 days. Participants must pay a nominal fee in order to undergo the training, either through a sponsorship organization or personal investment. Each month the health leader is required to implement what they have been taught at the community level through various activities and with the help of HFF mentors. These activities are to ensure that the health education percolates to the community through the health leaders.

Each month the health leaders are taught different topics. They are taught about public health programs, environmental and personal hygiene, nutrition, and prevention of common illnesses. A complete list of topics and a time schedule for the second batch are shown in Table 5.2.

Month	Session held
1	National Health Programs, Healthcare Scenario in India & Levels of Health
	Communication
	Levels of Health Care
	Personal and Environmental Hygiene
	Explaining of Survey Form
	Nutrition
2	Basic Human Anatomy
	Understanding & Prevention of diseases
	Project Planning
3	Pregnancy, Lactation
	Child Health
	Nutrition
	Nutrition
	Adolescent Health, Menopause
4	Nutrition
	First Aid
	First Aid
	Introduction of Insurance
5	Common Illnesses
	Common Illnesses
	Soak Pits
6	Men's Health
	Men’s Health
	Kitchen Garden

Table 5.2 *Health Education Topics*

In addition to being taught about these health topics, health leaders are also taught tangible skills, including how to develop and administer demographic, KAP (Knowledge, Attitude, Practice), and Health Needs surveys, how to effectively communicate in large groups, how to plan and implement various health projects, and how to administer basic

first aid. Topics that were not covered in this batch and that will be covered in the forthcoming training sessions are shown in Table 5.3**.**

Cancer (Cervical, Breast, Oral)
Infertility, Puberty
Health of Elderly (eye problems, hearing problems)
Administration of drugs (how to use eye drops, nose drops, vaginal pressaries, etc.)
Developing the Community Health Fund
Basic financial management, accounting, and book keeping
Home remedies for common health problems
Accidents

Table 5.3 *Additional Topics to Be Covered in Next Batch*

The HFF health training model is unique in incorporating a practical aspect to the training. Health leaders are required to implement the theory they learn in the health sessions. They do so by conducting surveys, holding community health sessions to discuss what they have been taught, and by executing a health project specific to the community's needs. Project topics include building soak pits (mechanism for improved sanitation) and spreading information about maternal/child health, various addictions, or men's health. Upon completion of the training program, health leaders are awarded a certificate, with which they may seek other job opportunities in the healthcare sector. This benefit is in addition to the advantages the health leaders gain personally from the health education and the benefits that the community receives as a whole.

INITIAL ASSESSMENT

An initial assessment of the second batch of health education training was conducted in the months of July and August of 2009. Because the training program was still being finished when this case study was constructed, the aim of the assessment was to

understand what impact had been made so far in the lives of the health leaders and the community members. Furthermore, it was conducted to identify where improvements in the training program could be made for the next batch of training. The assessment was performed with the following objectives, separated into two parts:

Analysis of HFF's Health Education Training Program:

1. To measure the efficacy of the training program (to this point) in terms of actions taken by health leaders.
2. To measure the reach and percolation of the health education to the communities through the health leaders.
3. To determine where, if any, problems lie by comparing responses between community members and health leaders.
4. To determine where, if any, problems lie by comparing responses between mentors and health leaders.
5. To measure the impact (to this point) of the training on the lives of health leaders through interviews with current health leaders and past.
6. To understand what improvements can be made with the health education training program.

Comparison of Healing Fields Foundation and ASHA:

7. To compare HFF's and the Indian government's ASHA health education programs to understand where the differences in training lie between the different programs, and to explore for potential areas of collaboration.

To fulfill these objectives the assessment was based on analysis of a set of interviews with current health leaders, past health leaders (mentors), community

members, and ASHA workers (ASHA Workers are government health workers, as part of the National Rural Health Mission) undergoing additional health education training with Healing Fields Foundation.

Analysis of HFF's Health Education Training Program

A total of 15 interviews were conducted: 8 current health leaders, 4 mentors (health leaders that were trained in the 1st batch), and 3 ASHA workers currently undergoing HFF training. Additionally, focus group discussions (FGDs) were held with members of 3 separate communities.

Efficacy of Health Training Program

Interviews with the 8 health leaders currently being trained with HFF lasted for approximately 30 minutes each. These interviews covered the following topics (see supplementary document for full questions and responses):

1. The experience and perception of the training program.
2. The experience with the community health sessions that were conducted as part of the training program.
3. The application and the results of the training program.
4. The extent and effectiveness of the various community health topics.
5. The individual projects carried out as part of the training program.

Of the eight respondents, four were males and four were females. Three respondents were under the age of 20, three respondents were between the ages of 21 and 30, and two respondents were between the age of 31 and 35. All of the respondents had been educated to at least the 10th standard. Six of the respondents were members of rural communities, while two were from urban communities.

The first section of the interview dealt with the respondent's experience with and perception of the training program. The respondents' overall assessment of the training program included:

Positives	Negatives
Gained knowledge about previously unknown topics *(4 respondents)*[1]	Sometimes the material is repetitive (either in group sessions or from month to month) *(2)*
Gained confidence in talking to the community *(2)*	Problem with language – can't understand Telugu *(1)*
Doctors provide relevant health information *(1)*	More doctors need to come during the training session (for different diseases) *(3)*
Have applied the training both personally and at the community level *(2)*	Doctors need to come on time *(1)*
-	Three days for training would be better than four *(1)*
No response *(2)*	No response *(1)*

Table 5.4 *Overall Assessment of Training*

The respondents overall assessment of the assignments included:

Positives
Training for assignments was complete and sufficient. *(1 respondent)*
People in the community are listening to what the health leaders are saying and are changing their habits accordingly *(1)*
The community is helpful in administering the assignments *(1)*
No response *(5)*

Table 5.5 *Overall Assessment of Assignments*

In terms of the topics covered in the health education training, two of the eight respondents stated that more topics need to be covered. One of those respondents complained that the doctors are only stating 25% of what is written in the literature passed out to them.

[1] The italic numbers in these tables signify the number of respondents who used these specific statements to describe aspects of the program.

Six respondents stated that the length of the training (four days) was appropriate. One respondent suggested that shortening the training to three days would increase the number of health trainees, and one respondent stated that three days would be better. All eight respondents stated that the frequency of the training (once a month) was appropriate.

In regards to the groups sessions model that is used during the training, five respondents stated that the group sessions are helpful, with two respondents specifying that the group sessions helped them to interact with and get to know other trainees. Two respondents stated that the group sessions were not helpful, with one specifying that they were repetitious. One respondent gave no response.

The second section of the interview asked the respondent questions about the health sessions they were to conduct in the communities during the training program. All eight respondents stated that they conducted health sessions, with two respondents stating they also conducted door-to-door health sessions. Seven respondents held bi-monthly health sessions, while one respondent held only monthly sessions. The average number of members attending the health sessions was 28 members.

During the health sessions, members of the community asked various questions to the health leader, including:

- What information more than the ASHA worker can you provide?
- What is the point of kitchen gardens?
- You provide health information, but do you also provide health care and medicines?

In response to the questions posed during the health sessions, two respondents stated that if they don't know the answer, they contact HFF representatives. One respondent stated that if they don't know the answer, they don't call for help; rather, they wait for the training session.

In the HFF health education program, participants of the first health education batch are required to mentor the current health leaders. Mentors are required to help the current health leaders in conducting the health sessions and in their individual projects. While four of the respondents stated that the mentors provide support their work, the other four respondents stated that the mentors need to provide more support. Some mentors are available by phone and some only have come once during the course of the entire six month training.

Finally, seven of the eight respondents claimed that the health education training had raised the level of respect and trust for them within the community. Only one respondent indicated that they plan to use the training for future jobs. When asked whether they had used the knowledge from the training in their personal lives, all the respondents claimed that they had in fact used the knowledge.

The third section of the interview asked whether the health leader had conveyed to the community various health topics they had been taught in the training program.

Only three respondents stated that they were aware of the community health fund, and all three of the respondents had either not told the community about it, or not approached the Panchayat about it. This is particularly important to note because the health trainees were distinctly informed about this health fund during the training

sessions. Very few individuals, as discussed in Chapter 4, know of the existence of the community health fund in particular.

Seven respondents stated that they had discussed nutrition with the community, while one respondent said they had somewhat discussed nutrition. Some topics covered include eating more green vegetables, eating more fruits, eating less meat, and eating less oil. The respondents did not provide any more specifics. Seven respondents also stated that they had discussed immunizations with the community. All eight respondents claimed to have discussed personal hygiene. Six members stated that they discussed maternal and child health. However, only three respondents stated that they had discussed prevention of common illnesses with the community.

Regarding the common illnesses prevalent in their communities, the health leaders primarily mentioned body pains and fever, while a few also mentioned jaundice, stomach pains, and diabetes. Interestingly, the high prevalence of diabetes was seemingly present mainly in the communities that were predominantly Muslim. Two respondents stated that the training only somewhat provided them with information about these illnesses, while the rest stated that the training had provided them with relevant information about the illnesses.

The fourth and last section of the interview covered the individual projects that the health leaders conducted. Three respondents conducted their project on soak pits. Two of these respondents had completed 2 soak pits each, while the third had completed 12 soak pits. The main reason for this disparity seems to be the level of support offered by the community itself. One of the respondents who had completed only 2 soak pits claimed that

the community refuses to partake in the project. All three respondents want to complete more soak pits. Both need more support from the community, the Panchayat, and HFF.

Three respondents conducted their project on maternal/child health. The three respondents identified an average of 11 lactating mothers and 5 pregnant women in their communities. All three respondents offered information to the mothers about nutrition. Specifically, the respondents spoke to the mothers about eating protein (through eggs), not being stressed, and resting. They also spoke to them about the proper immunizations for their young children. One respondent said that previously mothers did not take their young children regularly for immunizations. Since the health leaders have discussed immunizations with the mothers, however, they have begun to go for immunizations regularly. All three respondents claimed that the training was sufficient for them to carry out their project. Finally, one respondent conducted their project on flourasis, and one respondent focused on addictions.

Overall, one of the largest challenges to success in the projects is lack of support for the health leaders. In fact, only one respondent stated that the mentors were helping in project implementation. One respondent stated that the mentor needs to attend more than just the final day of the training sessions. Another respondent claimed that the community members also need to take action. Other than this lack of support both from the mentors and the community members, the respondents did not identify any additional challenges to project implementation.

Percolation

To measure the percolation of the health training to the community level through the health leader, focus group discussions were held with members of 3 communities.

Furthermore, separate interviews were also conducted with the health leaders of those communities, so as to compare responses to understand whether any disparities in responses existed.

The focus group discussions in each community provided encouraging results. In each community the members spoke pointedly of what had been discussed in the health sessions held by their health leader. They spoke relatively knowledgeably about nutrition, personal hygiene, common illnesses, and maternal health. When asked where improvements can be made, they stated that they would like to know more about new diseases such as the swine flu and how to prevent contraction of the disease. They also claimed that they needed a more extensive discussion about prevention of common illnesses, such as malaria and pneumonia. In another community, when asked if they had learned anything about personal hygiene, only one out of the three respondents said she had learned something. Overall, however, the sentiment amongst the members of each community was that the health sessions were useful.

Mentors

Finally, interviews were conducted with four individuals who had undergone HFF's health education training during the first batch. These four individuals are now required to be mentors for the current health trainees. These individuals were interviewed for three primary objectives:

1. Compare the mentors' responses with the health leaders' to understand where the problems lie.
2. Understand the mentors' view on how the current training is different from their own.

3. Understand what impact the training has had on the lives of the mentors.

According to the mentors, they visit the field an average of approximately 3 times a month. The respondents claim that these visits take anywhere from 30 minutes to the entire day, which includes traveling time. While the time that it must take for a field visit seems valid, the responses of the mentors seem to conflict with the responses of the corresponding mentees. While the responses of two of the four respondents match with their mentees, the responses of the other two respondents do not. For example, while one of the respondents claims that they make 2 to 3 field visits per month, the corresponding interviewed mentee, or health leader, claims that the mentor does not provide the support that they need for their assignments and project implementation. Thus, one of the focus areas of improvement for HFF's future batches should be to strengthen the mentoring program to provide the necessary support to the health leaders.

The next section of the interview asked the respondent how to improve the training process. One of the respondents suggested that the training program incorporate a hospital visit on the last day of the training to increase the confidence of the health leaders and their ability to be active. Another respondent suggested that the extensiveness of the topics be increased. Finally, a third respondent advised that HFF should select health leaders who are of an older age. This particular respondent mentors three different individuals, two of whom are under the age of 20, and one of whom is over the age of 30. While the two younger health leaders have only completed two soak pits in their communities, the elder health leader has completed 12. The respondent claims that being older in age makes it easier to command the attention of both the community and the Panchayat, and thus explains the difference in the number of soak pits completed.

COMPARISON OF HFF and ASHA:

The second part of the initial assessment is a comparison of Healing Fields Foundation's health education program with the government's ASHA health education program. "Accredited Social Health Activists", or ASHAs, are female health volunteers as part of the National Rural Health Mission, a scheme launched by the Indian central government in 2005 to increase access to health providers in rural areas. This section of the assessment is based primarily on an extensive comparison of the two programs (See Figure 5.1), supplemented by a set of interviews with ASHA workers who are currently undergoing HFF's training.

According to the Reading Manual for ASHA, the aim of this program is to create a band of female health volunteers that will "act as a 'bridge' between the rural people and health service outlets and will play a central role in achieving national health and population policy goals." In comparing the ASHA health education program with that of Healing Fields Foundation's, many similarities exist between the two in terms of their vision, mission, and objectives. However, at the same time, important differences remain, most prominently in the health topics covered, the method of training, and the tangible skills taught in each program. Each of these differences will be examined in order to understand how a partnership between HFF and the Indian government's ASHA program would be beneficial not only for both partnering entities, but also for the very individuals that these programs are seeking to help.

Health Topics

The first area of difference between the HFF health education program and the ASHA program is the extensiveness of the health topics covered. There are several illnesses covered in HFF's program that are not covered in ASHA's. For example, ASHA does not cover flourasis, cholera, gastroenteritis, typhoid, or jaundice. Furthermore, while the HFF program discusses the costs and procedure for the solution to each illness, the ASHA program does not. On the other hand, the HFF program does not cover herbal remedies in as much depth as the ASHA program. However, the topic of herbal remedies has been identified as one that will be taught more thoroughly in the next health education batch. The differences between the two programs in their breadth of health topics are admittedly few. However, what differences and gaps do exist in the ASHA program can be addressed through a partnership between the two programs.

Training Method

The second difference where Healing Fields Foundation offers a unique model, and where it can add the most value to the ASHA program, is in its method of training. There are four specific methods used by HFF that are unique. The first has to do with the length and frequency of the training. The Healing Fields Foundation training program has duration of six months, in which the health leaders come together once a month for four days. The ASHA training is different in that it is a continuous program of 21 days. This is a potential problem for the ASHA program, in that it can be too much information at once. Two of the three interviewees claimed that they had forgotten much of the information they had learned in the ASHA training four years ago, and that the HFF training program offered a review. While this could be simply because the ASHA training was four years ago, it is highly possible that the nature of the continuous 21 days of training offers too much

information at once, making it hard for the trainee to retain all of the information. This can be remedied by staggering the training program over the course of six months, as HFF has done. By meeting once a month for six months, the HFF program also allows for review of the material previously covered in each subsequent month, thereby increasing retention.

Furthermore, the issue of retaining the information is addressed in the HFF program by the incorporation of a practical element. This is the second unique method of training that HFF offers. After each monthly four-day training session, the health leaders are required to hold health sessions with their community to convey the information they have learned in the training program. Furthermore, after each training session, the health leaders must complete assignments in their communities. By practicing the theory that they learn in the sessions, the aim is to increase retention of the material. Because the ASHA program is for a consecutive 21 days, it cannot offer the depth of assignments and the application of theory that the HFF program is able to offer. Table 5.6 offers examples of assignments, as part of the HFF program:

Month	Assignments
1	Develop one nutritious recipe using locally available foods. For a group at their village. Conduct a KAP Survey with at least 25 members of their community
2	Relate an incident of hospitalization in their family or acquaintance and ask about the expenditure and how the funds were arranged.
3	List out the beliefs related to pregnancy and lactation in their area.

Table 5.6 *Assignments*

The third unique method of training offered by HFF is the group work and presentation model. All three interviewed respondents stated that while both the ASHA program and the HFF program incorporated group work into their training program, the

HFF program offered group presentations in addition to the group work. These monthly presentations help to increase the trainees' communication skills and confidence, vital to their success in the communities.

The fourth method of HFF training is the mentoring component. In the ASHA model, the Government of India has set up an ASHA Mentoring Group, through which NGOs and well-known experts on community health are to offer support to the ASHA workers. However, when asked about mentoring and other support offered through the ASHA system, all three respondents stated that the only support they receive is from their interactions with the ANM. Thus, there is significant room for improvement in the implementation of the ASHA program mentoring process. The HFF mentoring model rests on the notion that the previous batches' health trainees are to mentor the current health trainees, with the cycle continuing every batch. The mentor is required to support the health leader with completing their assignments, conducting health sessions, and implementing their specific projects. They are required to visit each health leader and their community twice a week, in addition to answering any questions over the phone and during the training.

Skills

The third area of difference between the HFF program and the ASHA program is the tangible skills taught in the programs. There are three sets of skills taught in HFF that if taught to the ASHA workers, would help to improve the latter. The first is teaching the health trainees how to design and administer a survey to understand the health status of their community. This is done after the first month of training. Developing and administering this survey helps the health trainee to understand how to design a survey, to

better their communication skills, and to improve their rapport with the community members. Under the ASHA program, health trainees are advised to conduct a health needs survey to ascertain the health status of the community. However, none of the three respondents said that they had conducted a health needs survey in their community. Thus, implementation of these surveys can be strengthened.

The second set of skills taught in the HFF program stems from the project planning. The health trainees are required to carry out individual projects specific to the needs of the community. They choose from soak pits, maternal/child health, addictions, flourasis, men's health, and kitchen gardens. Not only do these projects allow the health trainees to leave a visible impact in the community, but also, there are specific sessions to help build project-planning skills. These include initiating, planning and design, executing, monitoring/controlling, and closing for the project. The ASHA program does not have a similar program in which these skills are focused on. In fact, all three respondents agreed that there was no project planning skills in the ASHA program.

The third set of skills taught in the HFF program is skills to administer first aid. While the ASHA training program includes first aid, the HFF program is able to offer a more thorough first aid program. HFF partners with St. John's Ambulance to teach first aid skills. In fact, during the HFF training health trainees practice administering first aid for minor accidents. Of the three respondents, one claimed that first aid had not been a part of her ASHA training. The other two respondents stated that while first aid had been incorporated into the ASHA training, it was not very thorough.

Thus, while there are numerous similarities between the HFF and the ASHA health education program, differences still remain. A partnership between the two programs, in

which Healing Fields Foundation can become an accredited trainer of ASHA workers, would help to improve the ASHA program tremendously. Although the topics covered may be similar between the two programs, the additional skills taught through the HFF program can be highly valuable to the ASHA workers. This public-private partnership can then scale around India to provide the proper health education and health services to individuals living in communities that will benefit the most from this work.

CONCLUSION

Healing Fields Foundation has built a solid foundation for its health education program, as its extensive health education topics are unique and an asset. While the strengths of its program are quite visible, there are still challenges that need to be overcome in order to further develop and grow the program. Some of the main challenges that should be addressed or improvements that should be made include:

1. Provide greater incentives for the mentors to fulfill their responsibilities. The mentorship program must be strengthened further.
2. Engage the community so that they provide the necessary support for the success of the projects carried out by the health leaders.
3. Partner with the government to become an accredited health education trainer of ASHA workers. This will allow the HFF program to scale rapidly.
4. Develop a method to continuously engage and motivate the health leaders to work even after the health training program has been completed.

The main thrust of Healing Fields Foundation, then, is to build health education leaders by selecting individuals from the rural communities themselves. The focus of their

health education rests on the first and second types of information discussed in Chapter 3: information about public health measures and information about the need for particular health services, the existence of these health services, and how to access these health services. These two types of information not only improve the health of the individuals, but also empower them to access and *understand* the services that they are receiving.

India's future development rests heavily on its ability to provide affordable, quality health care to its entire population, and it seems increasingly vital for organizations such as Healing Fields Foundation to grow rapidly and impact the lives of an increasing number of people. This goal can be achieved through a mutual understanding between organizations such as HFF and the Indian government that public-private partnerships are one of the most efficient ways of educating poor individuals about health and ultimately, improving their health status. Health education of the communities is a vital step towards a more bottom-up and more democratic solution to the challenges that India's health care system still faces, and it is only through sustained effort to implement similar changes throughout India that its health system will improve.

#	Comparison Indicator	Healing Fields Foundation (HFF)	Accredited Social Health Activist (ASHA)
1	**Target area**	BPL citizens	Remote rural areas, including tribal, desert, hilly areas
2	**Area-Dependent Training?**	Yes; basic training same, but specific project training tailored to needs of local population	No; training is same for all workers
3	**Selection of Health Workers**		
3A	General Process	1. Health leaders selected from local NGOs 2. Health Leaders selected by SHGs and individuals coming forward	1. Block Nodal Officers identify 10 facilitators (appx. 1 per village) from local NGOs, Community based groups, Mahila Samakhyas, Anganwadis or Civil Society Institutions. 2. Facilitators interact w/community through FGD's to create a list of 3 names for potential ASHA workers who meet the selection criteria 3. Gram Sabha selects one person as ASHA worker. Village Health Committee approves.
3B	Criteria	-	
	Education	Ability to read and write in local language	Minimum of 10th class or Madhyamik passed - sources differ
	Gender	Male/Female	Married/Divorced/Widowed Female
	Age	Above age of 18	Between ages of 21-45
	Location	Familiar with area and its inhabitants, preferably a resident on the village/community	Resident of village for which she is selected
4	**Training**		
4A	Length	Total of 27 days over course of 6 months	Total of 23 days over course of 1 year
4B	Frequency	6 rounds (5+4+4+4+5+5)	4 rounds (10+4+4+5)
4C	Retraining	Review once a year for 2 years	Once every 2 months for 2 days each
4D	Procedure	Doctors and representatives from Fernandez Hospital, National Institute of Nutrition, and St. John's Ambulance train the health leaders	Cascade Model: Individuals at block/district/state level trained by local NGOs. Block trainers train ASHA workers
4F	Group Sessions	Yes - Discussion of 4-5 trainees during training session to discuss the topics learnt; includes presentations	Yes - but does not include presentations
4G	Meeting with Community	2-3 sessions per month during training period. At least once a week for one health education session and an ongoing project for 6 months, on the job training	On-job support after initial training
4H	Venue	Currently center in Hyderabad; Soon through e-learning, training will occur at community levels	Location near ASHA worker living area; PHC or Panchayat Bhavan
4I	Topics		
	Determinants of Health	Yes	Yes
	Staying Healthy	Yes	Yes
	Environment	Yes	Yes

Personal Hygiene	Yes	Yes
Water Sanitation	Yes	Yes
Nutrition	Yes - Age, Gender Specific	Yes
Human Biology	Yes - More Extensive	Yes
Home Remedies	Yes	Yes
Community/Gender Rights	Yes	Yes
Adolescent Health	Yes	Yes
Communication/Leadership Skills	Yes	Yes
Health Services (Government/Private)	Yes - Public Health System and Network Hospitals	Yes - Public Health System
Immunization	Yes	Yes
Flourosis	Yes	No
Herbal Remedies	No - Very scarce comparatively	Yes
Contraceptive Methods	Yes	Yes
Pregnancy, Birth, Post-Natal Care	Yes	Yes
Child Health	Yes	Yes
Common Medical Problems	Yes	Yes
National Health Programs	Yes	Yes
Anganwadi/JYS/Dai	Yes - Covered in Government System	Yes
Accidents & First Aid	Yes - More Extensive, St. John's Ambulance TRG	Yes
Wound Care	Yes - St. John's Ambulance TRG	Yes
Health Scenario in India	Yes	Yes
Month Long Projects	Soak pits, Lactating Mothers, Flourasis, Adolescent Girls, Garbage Compost, Addictions	No similar projects exist
Illnesses (causes/remedies)		
Swine Flu	Yes	No
Cholera	Yes	No
Malaria	Yes	Yes
Gastroenteritis	Yes	No
Typhoid	Yes	No
Jaundice	Yes	No
Pyrexia	Yes	No
Pneumonia	Yes	No
Tuberculosis	Yes	Yes
Asthma	Yes	No
Acute Respiratory Infection	Yes	Yes
Genital Infections/HIV	Yes	Yes
Dengue Fever	Yes	No
Diarrhea	Yes, Covered under Gastroenteritis with special emphasis on children	Yes
Thyroid	Yes	No
Chikungunya	Yes	No
Bronchitis	Yes	No
Snake Bites	Yes - St. John's Ambulance	Yes
Costs and Procedure for Solution for each Illness	Yes	No

5 Roles/Responsibilities

5A	Create awareness of determinants of health (nutrition, hygiene, sanitation, living/working conditions, etc.)	Yes	Yes
5B	Disseminate knowledge about existing healthcare services and about timely utilization of services	Yes	Yes
5C	Facilitate access to healthcare facilities	Yes	Yes
5D	Develop and implement health education at grass roots level to prevent illnesses and epidemics	Yes	Yes
5E	Create awareness about alternate healthcare finance mechanisms like insurance programs and health savings	Yes	No
5F	Disseminate knowledge of different government health programs and build linkages with gov. healthcare agencies	Yes	Yes
5G	Design and implement preventive health programs.	Yes	No
5H	Counsel women on birth preparedness, safe deliver, breast feeding, immunization, prevention of STI, etc.	Yes	Yes
5I	Work with the Village Health & Sanitation Committee of Panchayat to develop a comprehensive village health plan	Yes - A part of project TRG	Yes
5J	Escort/accompany pregnant women and children requiring admission to the nearest health facility	No - Refer to ASHA	Yes
5K	Provide primary medical care for minor ailments and first aid for minor injuries.	First aid for minor injuries	Yes
5L	Act as a depot holder for essential provisions such as rehydratoin tablets, iron folic acid tablets, condoms, etc.	No - Will educate how to utilize these provisions	Yes

5M	Will inform PHCs & subcenters about births, deaths, and unusual outbreaks in her village	No	Yes
5N	Promote construction of household toilets under Total Sanitation Campaign	Yes - A part of project TRG	Yes
5O	Role as Provider can be enhanced	Milestones, Immunization, Common ailments of childhood illnesses	Yes: Graded training for providing newborn care and management of common ailments particularly childhood illnesses
6	**Additional Skills Taught**		
6A	Communication	Includes education to communicate effectively with local community and develop leadership skills. Direct action steps for effective communication are unique to HFF.	Includes education to communicate effectively with local community and develop leadership skills.
6B	Project Planning	Session on effective project planning - 5 stages of project planning (initiation, planning/design, executing, monitoring/controlling, closing)	None
7	**Assessment of Needs**	HFF Health Leader conducts 30 surveys in her first month of training as part of certification to determine the health needs of local population. Health projects are tailored to the specific needs of the local population.	ASHA worker advised to perform house-to-house survey in her village to determine health needs of her village
8	**Collaboration Entities**	Local NGOs, Self Help Groups, Microfinance Organizations, Local Hospitals, Gram Panchayat	Local NGOs, Self Help Groups, Anganwadi Workers, ANMs, Gram Panchayat
9	**Mentoring**	Previously trained health leaders and NGO staff mentor current trainees with 2 assignments in the field during training	None - works with other government workers, including ANMs and Anganwadi workers
10	**Monitoring**		
10A	Documentation	3 Surveys - General, Project-Related, and post training survey	Documentation of meetings conducted
10B	Feedback	Feedback forms completed after each training session; feedback also provided on training after each month (suggestions, criticisms, etc.)	None
11	**Compensation Received by HWs**	Health leaders pay a fee of 100 rupees per month to be trained	No salary; Training compensation: 100 rupees/day; Performance-based payments
			Drug kit provided to provide basic health care
12	**Impact**		

12A	Indicators Used	Change in # of health claims, # of soak pits/community gardens, health-seeking behaviors, incidence and prevalence of communicable diseases Pre/post test for health leader, Nutritional intake of pregnant and lactating mothers, nutrition of children, reduction in number of preventable illnesses, increased utilisation of providers (especially government providers), uptake of insurance programs	Changes in Infant Mortality Rate, Child Malnutrition Rates, # of cases of TB/leprosy as compared to previous year.

Figure 5.1 *HFF vs ASHA Worker Comparison*

Chapter 6: National Policies

Elimination of disparities in health outcomes and health service utilization between the wealthy and the poor can be achieved through a combination of information dissemination and increased political will to create pro-poor policies. Through pro-poor policies public services can be targeted to the poor, particularly in rural areas, where individuals face perhaps the most serious inequities in health care services. As the previous two chapters showed, information dissemination can by itself lead to increased interaction with health providers and government officials and increased demand for health services. In addition, increased information can also pressure policymakers to create and implement pro-poor policies through increased accountability and decreased clientelism.

What remains to be discussed, however, is *how* increased information among the poor undergirds pro-poor policies. Also, so far this study has not explicitly defined what a pro-poor policy is. Thus, this chapter will both delve into what pro-poor policies are and discuss how information provides the basis for them. This chapter is divided into two sections. The first is a discussion of what a pro-poor health policy entails and how it takes into consideration the barriers that the poor face in terms of improving their health and receiving and accessing proper health care services. This section will also discuss how pro-poor health policies can improve health delivery in India through demand-side solutions, specifically in rural areas, and how these policies are an alternative to the clientelist politics. In addition, a metric will be developed to specify what exactly constitutes a pro-poor policy. This metric will then be used in the second section to evaluate the National Rural Health Mission, an initiative launched by different Indian states, to determine whether these health policies are indeed pro-poor.

PRO-POOR HEALTH POLICIES

The implications of the ability of politicians to engage in clientelist politics and be held weakly accountable are profound for health outcomes among the poor, especially for those living in the countryside. While inequalities in health outcomes and health service use are already tremendous in India, the persistence of an unequal political environment threatens to widen these inequalities further. Alarmingly, the pattern of the health sector in India, as in many other developing nations, can *cause* greater inequalities in health outcomes and health service use (Yazbeck 2009). Because accountability mechanisms are wanting and because health policies are not pro-poor, health service use accrues to the wealthy, as discussed extensively in the Chapters 2 and 3. The question in this section, then, is *what is a pro-poor health policy, and how can such a policy help improve health outcomes for India's rural poor, thereby reducing inequalities?* To answer this question, and to help organize our thinking, a diagram has been created to outline the factors that constitute the preferences of the poor, the systemic and individual constraints to fulfilling these preferences, and attributes of policies that can address these constraints (See Table 6.1).

PREFERENCES	CONSTRAINTS			ATTRIBUTES
	Pro-Poor Bias	Supply-Side	Demand-Side	
Avoid preventable morbidity and premature mortality.	Prone to risk factors	Insufficient funding	Limited individual resources	Addresses demand-side barriers
Adequately nourished	Lack of water/sanitation	Inconvenient location	Transportation costs	Involves the poor
Access to high quality and affordable healthcare		Long wait/inconvenient hours	Opportunity cost of travelling	Malleable to local context
Dignity		Perception of local quality	Financial cost is high	Transparency
		Not treated with respect/care	Low education	Accountability mechanism

	Few resources at PHCs	Preference for traditional healers	Continual evaluation
	Corruption	Cultural norms	
		Low health-related knowledge	

Table 6.1 *Preferences and Constraints to Receiving Health Care; Pro-poor Policy Attributes*

The type of pro-poor policy advocated for here places the individual at the center of the analysis, and for this reason, many of the arguments developed in this section and the next will focus on attributes of the poor individual. The dependent variable in the following analysis is the inequality in health service use between the better off and the poor, which itself is a primary reason for the inequality in health outcomes (Yazbeck 2009). With the individual at the center of the analysis, the argument is based on addressing the demand-side barriers—the independent variables—to adequate utilization of health services to reduce inequalities. Health policy interventions have to a large extent been focused on supply-side barriers, such as insufficient funding to primary health centers, availability of supplies at the clinics, and attitude of the medical workers. While these interventions are clearly important, demand-side barriers, such as lack of health knowledge, lack of information about health programs, and cultural norms are just as important; however, interventions have not focused on these barriers. Here, by explicitly focusing on the demand-side barriers, the argument not only addresses the constraints that the poor individual faces directly in accessing proper health services, but also, it provides a mechanism through which the individual can increasingly exert her voice in a democratic system that is based on asymmetries of power.

Pro-poor policies aiming to reduce inequalities in health service use must center on demand-side barriers, and must focus on increasing health service use among the poor by

engaging these individuals directly, and involving them in the process. Thus, effective pro-poor policies begin with an understanding of the preferences of the poor individual himself. In a political system where power distribution is greatly unequal, by beginning with the poor individual, policies can be created that cater to the needs of the poor directly. The first step in developing a pro-poor policy is to identify the poor, who are often members of disadvantaged groups, including individuals living in rural, tribal, and hilly areas (geographically very isolated) and members of low castes.

The second step to be addressed in constructing attributes of a pro-policy, then, is to isolate the preferences of the poor. By preferences, we mean those capabilities that every human has reason to value. We cannot pretend to know every preference of every human being; however, there *is* a universal set of preferences, or capabilities, that every individual desires to be fully human (Nussbaum 2001). The specific preferences outlined in this argument are in part drawn from this set of universal capabilities: all human beings should have the capability to live a life of normal length and not die prematurely due to a preventable cause; they should have the ability to be sufficiently and properly nourished; they should have access to health care that is both affordable and of adequate quality; finally, they should have access to health care in a non-humiliating manner, in that they are treated with respect and dignity.

Unfortunately, too often for poor individuals living in India's countryside these preferences are not met. The average life expectancy for a male living in India is 62 while for a female it is 64.[1] In comparison, the average life expectancy for the United States is

[1] WHO 2006

77.7[2] and for China is 73.[3] In addition, 276 out of 1,000 males and 203 out of 1,000 females have a probability of dying between the ages of 15 and 60 years.[4] India also contributes to 1 in 3 of the world's malnourished children,[5] with 44% of children under the age of 5 malnourished in India.[6] Furthermore, 25% of hospitalized individuals in 1995-1996 fell into poverty because of health care costs (Peters et al. 2002). Finally, receiving health care in a dignified manner from health workers that are respectful and not condescending is a variable difficult to measure on a wide scale. However, analysis of data gathered from the Medak district in Andhra Pradesh in Chapter 4 showed that lack of respect among the health workers is a significant barrier for the poor in accessing health services.

Thus, the insufficient fulfillment of these preferences for the poor in India's countryside is highly substantive. After identifying the poor, and with these preferences in mind, the next step in constructing a pro-poor health policy is to identify the constraints that prevent the poor from fulfilling these preferences and accessing sufficient health services. Table 6.1 outlines three types of constraints: supply-side barriers, poor-biased barriers, and demand-side barriers. While supply-barriers are important, at the risk of oversimplification, they can be thought of as barriers that are addressed through top-down interventions. As mentioned before, too many resources have been directed to eliminating these barriers, without paying much credence to demand-side barriers, which can be addressed through bottom-up solutions by directly involving the poor. These bottom-up

[2] CDC 2006
[3] World Bank 2007
[4] WHO 2006
[5] UNICEF <http://www.unicef.org/india/children_2356.htm>
[6] World Bank 2008

solutions can actually also help eliminate some supply-side barriers, as will be discussed in the next section.

Poor-bias barriers are those constraints that the poor face more than individuals who are better off: they are certain risk factors that affect the poor disproportionately more than other groups of individuals. For example, for a poor individual living in rural India, to be in a situation where there is a lack of clean water is more likely than for an individual who is better off. Furthermore, such a lack of water has more of an effect on a poor individual, as he or she does not have adequate resources to find different sources of clean water. Thus, these constraints constitute risk factors that although not directly related to proper health care, nonetheless affect the health of the poor by being negatively biased towards them.

Enson and Cooper (2004) define demand-side barriers as "those factors that influence demand and that operate at the individual, household, or community level." Demand-side barriers focus directly on why *individuals* do not use health service use at higher levels. A policy based on demand-side constraints to accessing health services thus also empowers the poor to exert their voice and to become more active contributors to solutions to increase their utilization of health services, and thus, their health. Furthermore, increases in health education and information undergird most solutions to the demand-side barriers.

Finally, the last step after identifying individual preferences and constraints to fulfilling those preferences is to determine what attributes constitute a pro-poor health policy. There are six attributes that address the previously outlined constraints and constitute a pro-poor policy. The first has been discussed already, and that is that a pro-

poor policy should explicitly address demand-side barriers, ensuring that the policy focuses on the poor by operating in a bottom-up approach in which the poor are directly involved. While this means that a pro-poor policy should focus on demand-side barriers, this does not preclude focusing on supply-side barriers as well.

This leads to the second criterion of a pro-poor policy: involve the poor. Involving the poor in crafting the policies themselves and in developing solutions to the constraints is a vital step in increasing health service utilization. In Attacking Inequality in the Health Care Sector, Yazbeck states, "The only way that a policy designed to attack inequality can be truly effective is if the targeted population is involved in the basic design of the policies intended to help them. Such participation can be accomplished through the seemingly simple act of *listening* (108)." Listening to and involving the poor therefore not only allows individuals to partake in the decisions affecting their lives and increasingly exert their voice in the political system, but also, it helps to contextualize the policy to the particular situation.

This, then, is the third attribute of a pro-poor policy: create malleability to the local context. The reasons why the poor do not use more health services can be different combinations of the barriers listed in Table 6.1. However, these combinations differ depending on the local context, and no general policy can address the specific needs of individuals in different contexts. This is particularly important in India, where the differences between states in health service utilization and health outcome inequalities are vast, and the reasons for these inequalities are equally disparate. Furthermore, decentralization has created a system in which malleability to the local context is increasingly possible to include in policies.

The fourth attribute directly addresses the high level of corruption present in India's political system, leading to a bias that is detrimental for the poor. Thus, transparency ensures accountability, the lack of which is a major cause for a low level of health care provision. The fifth attribute of a pro-poor policy is a logical extension: incorporate and develop accountability mechanisms to ensure that politicians remain credible in their promises. The effect of provision of information on improving public service delivery, as I have argued throughout this thesis, is heightened when combined with accountability mechanisms. Finally, the sixth attribute of a pro-poor policy is to incorporate a mechanism for continual improvement. Such a mechanism is important because it enables a constant evaluation of the policy to understand the reasons for its success or failure. Not only does this create dynamic policies, but also, lessons can be drawn from these policies and then directly replicated or revised in other situations.

Thus, by directly focusing on the poor individual himself, by concentrating on the demand-side barriers to accessing adequate health care services, and by also including involvement of the poor, malleability to the local context, transparency, accountability mechanisms, and constant evaluation, policies will be decidedly pro-poor. These pro-poor policies are an alternative to the clientelist environment that continues to exacerbate the inequalities in health service use and health outcomes among the poor and the better off. By directly involving the poor and being transparent, the policies also help to ensure that the accountability mechanisms will be in place. Furthermore, these pro-poor policies will diminish the unequal ability of individuals to exert their voice in India's democracy.

Finally, as argued in Chapter 3, the fundamental element that will allow these pro-poor policies to function effectively is increased information among the poor. While

information dissemination to the poor will reduce clientelism and increase accountability of both politicians and health providers, thereby encouraging the creation of these pro-poor policies, information is also highly interrelated with each of the attributes of pro-poor policies. How each information type supports specific attributes of pro-poor policies is outlined in Table 6.2; the specific types of information that undergird each attribute are from Table 3.3.

ATTRIBUTE	INFORMATION TYPE
1. Address demand-side barriers	Health education
	The need for and how to access relevant health services
2. Involves the poor	Need for community participation and social movements
3. Malleable to local context	Health education
	The need for and how to access relevant health services
	Need for community participation and social movements
4. Transparency	Budget allocation
	Actions of government officials
5. Accountability mechanisms	How to directly pressure government officials, health workers, and other medically trained personnel
	Information about proper complaint and redress mechanisms is also necessary.
	Need for community participation and social movements
	Need for associations
6. Evaluation mechanisms	Monitoring to assess relative effectiveness and condition of various health providers and government programs

Table 6.2 *Information Types Fulfilling Pro-Poor Policy Metrics*

EVALUATION: NATIONAL RURAL HEALTH MISSION

While the metric developed in the previous section for what constitutes a pro-poor policy is important in terms of guiding future policy, it is quite possible that current Indian government health initiatives are already pro-poor. This knowledge would help us to assess what aspects of current programs are working and what aspects are not, which would also be helpful in crafting future legislation and programs. Thus, this chapter will use the metric developed and evaluate the National Rural Health Mission (NRHM) to determine whether this specific health initiative is pro-poor. Furthermore, because there is a tendency in India for programs and legislation to target the poor in writing, but without actual implementation, this section will also incorporate an initial evaluation of the impact of NRHM since its inception. While the previous chapter explored facets of NRHM related to the ASHA worker program, this chapter will take a broader look at the initiative and its impact.

The National Rural Health Mission was launched in 2005 with the aim of "improving the availability of and access to quality health care, especially for those residing in rural areas, poor women, and children," and will continue to be implemented until 2012.[7] More specifically, the vision of NRHM includes a focus on:

- Raising government public health spending from 0.9% to 2-3% of GDP
- Promoting policies that strengthen public health management and service delivery
- Integrating health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water
- Decentralizing programs for district management of health
- Improving access of rural people, especially poor women and children, to equitable,

[7] Ministry of Health and Family Welfare. <http://mohfw.nic.in/NRHM.htm>

affordable, accountable, and effective primary healthcare.

In addition, NRHM aims to:

- Forge a partnership between the central, state and the local governments
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programs and infrastructure
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care (Bhawan).

Finally, the goals of NRHM are the following:

- Reduce infant mortality rates to 30 deaths per 1,000 births and maternal mortality ratios to 100 deaths per 100,000 individuals
- Ensure universal access to public health services such as women's health, child health, water, sanitation & hygiene, immunization, and nutrition
- Prevent and control communicable and non-communicable diseases.

Thus, the aim and the goals of NRHM explicitly address the first three of the four preferences of the poor discussed earlier: avoid preventable morbidity and premature mortality, be adequately nourished, and have access to high quality and affordable healthcare. However, there is no clear mention of ensuring access to healthcare in a dignified manner, as politics and interaction of shame create a significant barrier for the rural poor. Therefore, solely through its aims, NRHM does plan to address most of the preferences of the poor.

However, to evaluate whether NRHM is actually pro-poor, what must be studied are the strategies and the mechanisms through which the program plans to achieve its outlined aims. Thus, attributes of the program must be identified to determine whether they fulfill each of the criterions established earlier for a pro-poor policy. The first criterion of a pro-poor policy is that it explicitly addresses demand-side barriers, which are listed in Table 6.1. In general, the main thrust of NRHM is based on addressing supply-side barriers by improving health systems through changes in the facilities and in human resources. This is undoubtedly very important. Whether a policy is *pro-poor*, however, is dependent largely on the presence of explicit provisions to address demand-side barriers.

NRHM does contain specific elements that seek to shift some of the focus to preventive care instead of curative through increased health education. The Mission seeks "to work with the departments of education to make health promotion and preventive health an integral part of general education. The Mission would also interact with the Ministry of Labor for occupations health and the Ministry of Women and Child Development for women and child health to ensure due emphasis on preventive and promotive health concerns (Bhawan)." In addition, in terms of the lack of personal financial resources to access services, the Mission aims to develop risk-pooling mechanisms that either cross subsidize the poor or allow for more efficient demand-side financing of health services. Thus, although the main aim of NRHM is driven by motivations to eliminate supply-side barriers, it is also complemented somewhat with provisions for addressing demand-side barriers.

The second criterion of a pro-poor policy is that it needs to involve the poor in implementing the programs and improving health service delivery. Involving the poor can

be achieved through increasing community participation and providing the foundation for social movements. NRHM does address this criterion, as one of the central goals of NRHM is to develop an "architectural correction" (Sharma 2009) in which there is a larger emphasis on decentralization and communitization, through which there can be an increase in community participation in governing and maintaining health facilities in the rural areas. Furthermore, to institutionalize community led action for health, NRHM has purportedly sought amendments to acts and statutes at the state level to fully empower local bodies in effective management of the health system. NRHM also aims to transfer funds, functionaries, and functions to PRIs. Finally, one of NRHM's core strategies is to train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control, and manage public health services.

Specifically, one of the provisions of NRHM to increase community participation is the dispersion of an untied fund—community health fund—from the central government to the Panchayati Raj Institutions (PRI) throughout the country. This fund of 10,000 rupees was discussed in both Chapters 3 and 4, and its purpose is to help fund improvements for health facilities in rural areas and to address the health needs of the individuals living in these communities. In terms of how successful this objective has been, however, the process of increasing community participation has been quite slow. The untied fund, for example, has often been held up at the state and district levels; however, because the Constitution defines health as primarily a state subject, these funds have so far not been distributed from the central government directly to the local level (Sharma 2009). In other areas the process of utilization of this untied fund has not yet even begun (ibid).

Regardless of the level of success of NRHM in achieving the goal of increasing community participation and increasing the role of the PRI in rural health facilities, this specific goal is ultimately the correct one. The framework for NRHM does in fact point to the need to engage civic society and the need for community monitoring of health facilities. However, the core strategy through which NRHM aims to achieve this goal relies too heavily on the process of decentralization and not enough on directly engaging the individuals living in these villages. Instead of continuing to work through the PRI, NRHM needs to place an equal emphasis on raising awareness and information within the community itself by directly working with households and individuals. Overall, therefore, NRHM does seem to be placing the poor at the center of its initiatives; it still has room for improvement in making this involvement more direct and in the implementation of this strategy.

The third criterion is that the policy be malleable to the local context, which follows directly from increased decentralization and increased community participation. By focusing on decentralizing control and management of health facilities to the PRI, NRHM is also simultaneously addressing the fact that the local context should determine which aspects of the program to stress. Again, there is no explicit mention of the need to cater to the local context in administering aspects of NRHM. However, diversity in the local context can be addressed through the ASHA program and through community monitoring. The only instances where local needs are mentioned are those related to revitalizing local health traditions. Overall the three types of information that undergird this specific criterion are health education, information about health services, and awareness about the need for

community participation. All three of these information types have already been discussed and are indeed addressed by the language of the NRHM framework.

The fourth criterion is that the implemented programs need to be transparent, so as to increase accountability of both the health providers and the Panchayati Raj. Transparency rests largely on access to information about budget allocation and about government actions. NRHM recognizes the fact that the Panchayati Raj Institutions and individuals have very little say in the health system, and thus, they claim the PRI and user groups should have more control in the system. To achieve this, the NRHM aims to make it compulsory for all the health institutions to prominently display information regarding grants received, medicines and vaccines in stock, services provided to the patients, and user charges to be paid. The NRHM framework also includes provisions to share all data acquired from surveys of facilities and discuss the findings at the habitation/village level to ensure full transparency. Thus, the NRHM framework does explicitly address this criterion, although it is not clear whether these provisions are actually implemented on the ground.

The fifth criterion of a pro-poor policy is the incorporation of an accountability mechanism, which increases the effectiveness of information dissemination, and ensures that health service delivery is more properly executed. Perhaps the most direct form of an accountability mechanism is a method to properly complain about inadequate services, and a method to seek redress when necessary. This can be facilitated by community monitoring, increased information about entitlements, and the development and utilization of associations. NRHM, however, contains very cursory provisions for complaint mechanisms about weak service delivery to either the local government officials or health providers. It states that complaints about denial to health care can be brought to the

attention of different Committees based on different health facilities, and that these complaints *may* be passed on to the District level, which is a seemingly weak method for seeking redress. However, NRHM does take several steps to promote community monitoring through the participation of PRI representatives, user groups, and representatives of community based organizations and NGOs to facilitate their input in the monitoring planning process, and to enable the community to be involved in broad based review and suggestions for planning (Bhawan).

Thus, the need for associations is addressed by NRHM, stating that a system of periodic 'Jan Sunwai' or 'Jan Samvad' at various levels would empower community members to engage in giving direct feedback and suggestions for improvement in public health services. Furthermore, one of the core strategies of NRHM is to promote the development of Village Health and Sanitation (VHS) Committees, which consist of Gram Sabha members, community health workers (ASHA, ANM, Anganwadi), and self help group leaders. One of the functions of these VHS Committees is to create public awareness about the essentials of health programs, with a focus on individual knowledge of entitlements to enable their involvement in the monitoring. Furthermore, the VHS Committees can enable discussions and development of a Village Health Plan based on an assessment of the village situation and priorities identified by the village community, thereby contextualizing the health services provided to particular communities. Finally, VHS Committees directly provide accountability mechanisms by enabling individuals to bring complaints to the Committee, who can then communicate the complaints to the District and State level. Thus, VHS Committees do provide an accountability mechanism, in addition to supplying a method to contextualize health services and enabling community monitoring.

While in its language NRHM recognizes the importance of associations and community monitoring, it seems that a lack of political will remains and an attitude of indifference prevails, and meetings of the VHS Committees are not held regularly, if at all (Sharma 2009). Original surveys administered in the Medak district from Chapter 4 lead to a similar conclusion, since very few individuals had ever participated in or heard of the Village Health and Sanitation Committees. Overall, regardless of the level of success of this aspect of NRHM, and regardless of the emphasis on committees and associations, the fact that there is no firm complaint mechanism means that this particular criterion is not fulfilled.

The sixth and final criterion of a pro-poor policy is a mechanism for continual evaluation of the program itself. The National Rural Health Mission overtly recognizes the importance of this criterion by mentioning the need for monitoring and evaluation. Many of the listed strategies include collecting reports from the district, state, and national levels, and requiring subcenters to report on their performance to the Panchayats. As part of its strategy, NRHM states, "Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision."[8] However, in some respects it is very difficult for evaluation to occur because it was not initially built into the project design, meaning baseline figures and consistent state-level data are lacking. This hampers a yardstick assessment on how the mission is faring in various regions (Gill 2009). Furthermore, randomized evaluations are not feasible at this stage because NRHM has already been introduced across rural areas, precluding access to control areas where the mission has not yet been applied. Thus, although the program itself does recognize the

[8] Ministry of Health and Family Welfare

need for continual evaluation, because an initial mechanism for evaluation was not put into place, NRHM does not fulfill this criterion.

Overall, therefore, the National Rural Health Mission fulfills four of the six criteria of a pro-poor policy, as shown in Table 6.3. While NRHM addresses demand-side barriers, involves the poor, is malleable to the local context, and is transparent, it does not incorporate strong enough accountability mechanisms or evaluation mechanisms.

ATTRIBUTES	ADDRESSED?
1. Address demand-side barriers	Yes
2. Involves the poor	Yes
3. Malleable to local context	Yes
4. Transparency	Yes
5. Accountability mechanisms	No
6. Evaluation mechanisms	No

Table 6.3 *Criteria*

The National Rural Health Mission is an important step towards transforming the health delivery system to rural India. However, while the NRHM framework addresses many of the criteria of a pro-poor policy, it seems that implementation of various aspects of the program has been very slow, due largely to a lack of political will and a persistent lack of awareness among individuals of what they are now entitled to.

CONCLUSION

Disparities in health service use and health outcomes between the poor and the better off can be addressed in two ways: increased information dissemination among the poor and increased political will. This chapter focused on the latter, arguing that for health service delivery in rural areas to improve, there must be increased political will to both create *and* implement pro-poor policies. Lack of accountability and clientelism together

lead to this lack of political will, and ultimately, skewed political incentives. Health service delivery to the rural poor can be improved by developing policies that specifically target the poor. These policies focus predominantly on demand side barriers, thereby constructing avenues to engage the poor directly through increased information dissemination.

Evaluation of the National Rural Health Mission, the newest initiative launched to change the architectural design of the health system in India, showed that while it is in most respects a pro-poor policy in its language, implementation of the program has been slow due to a lack of political will. The piece that is still missing is increased political will to implement aspects of the program, which can be achieved through increased awareness about these entitlements, such as the benefits of the community health fund and the Village Health and Sanitation Committee. Increased awareness can lead to increased interaction with the individuals responsible for providing health services in the rural areas. Thus, information dissemination and pro-poor policies are not only intimately and bi-directionally related, but also, they can together lead to improved health outcomes among the rural poor.

Chapter 7: Conclusion

This study began with the notion that every human being should have the ability to live a life of full health and have access to adequate health services when needed. The aim has been to identify the reasons why the poor continue to face disproportionately lower health outcomes than the wealthy, especially in rural areas in India. While health is understood to be a fundamental right, and one that is vital not only for economic growth, but also for human development at the individual level, a large portion of India's population, and indeed the world's, continues to suffer from preventable diseases and a lack of access to basic health care services. My hope throughout this study has been to understand the barriers that the poor face in accessing these services, and ultimately, in improving their health outcomes so as to live fuller lives.

There have been several recurring themes throughout this study, and they underlie the main findings and observations of this project. What is perhaps the most striking, particularly in India's context, is the distinction between the level of health care services and the distribution of health care services. Scholars and government officials often argue that public health facilities and public health funding are as a whole inadequate, explaining the low health outcomes among the poor. This is true. Admittedly, public health funding and the extent of India's public health services are abysmally low, especially relative to other developing nations. However, it is also true—and this is an often-ignored fact—that the level of health care services, and the current funding, is actually sufficient to serve India's entire population. Chapter 2 discussed this at length, not only providing a descriptive background for India's health system, but also arguing that these common

arguments are inadequate, and that disparities can be eliminated instead through bottom-up solutions.

Because the public health facilities are actually sufficient, disparities in health outcomes and health care service utilization are therefore an issue more of politics than of medical care, and it is for this reason that I focus on the political incentives that preclude the poor from experiencing the same health outcomes as the better off. Chapter 3 discusses that in trying to understand the political landscape that contributes to the weaknesses in health service delivery, and more generally public service delivery, it seems unusual that in a democratic country where a significant portion of the population is poor and lives in rural areas, the poor are not able to voice their grievances and demand better health services. Lack of accountability, lack of credibility, and clientelism among politicians have led to this weakness in public service delivery, marginalizing the poor. However, it is precisely through democracy that the poor can voice their demands for better public health services. Enabling the poor to do so cannot be achieved solely through top-down solutions, such as increasing public spending and decentralization. Rather, empowering the poor is predicated largely on bottom-up solutions, which directly involve the poor.

Information dissemination is perhaps the most powerful bottom-up mechanism to empowering the poor to engage in preventive health measures and to demand their health entitlements from health providers and government officials. There are three different information types that together can help to diminish disparities in health outcomes and health service utilization among the rural poor and the better off in India. These different types include information about preventive health measures, information about the need for and the existence of particular health services, and information about how to demand

better health services from both government officials and health providers. While the first two types of information can directly improve health outcomes, the third type of information works through the accountability framework advanced by the World Development Report 2004, within which increased information among individuals strengthens relationships between both policymakers and clients and health providers and clients. Information is particularly important in health service delivery because information asymmetries are especially egregious in this sector.

Perhaps the most difficult type of information to provide is the third one: information about how to demand better health services. Furthermore, this type of information cannot empower the poor on its own. What is needed is a mechanism to facilitate the use of that information to interact with government officials and health providers in rural areas so as to demand better health services and monitor the services that are being provided. This mechanism to increase participatory action rests largely on the existence and utilization of community based organizations, or associations. Chapter 4 discusses explicitly the third type of information and the necessity of a combination of increased knowledge about entitlements and increased participation in associations to increase interaction with health providers and government officials, the first step in demanding better services and diminishing health disparities. Analysis of health surveys administered randomly in six villages to a total of over 120 individuals in the Medak district of Andhra Pradesh revealed that increased information about entitlements is a significant determinant of increased interaction with both health providers and government officials. The analysis also showed that increased participation in associations is a significant determinant of increased interaction with government officials. Thus,

increased information and participatory action can together enable the poor to interact more with administrative officials to demand better health services.

While the third type of information is important in indirectly improving health outcomes through increased interaction with administrative officials, the first two types of information—about preventive measures and health services—are more directly involved with improving health outcomes. In Chapter 5 I developed a case study of Healing Fields Foundation (HFF), an NGO based in Hyderabad, in addition to constructing a comparison between HFF's health education program and the government's ASHA program to examine which elements of these programs are successes and which are failures. This case study not only confirmed the importance of providing health education to the poor, but it also provided evidence for the importance of civic society, and particularly NGOs, in strengthening the ability of individuals to personally improve their health. Furthermore, this case study helped lead to the conclusion that public-private partnerships can be a beneficial mechanism to developing this sort of health education program.

Understandably, in addition to the dissemination of these three types of information, what is needed to improve health service delivery in rural areas is increased political will to create and implement pro-poor policies. The creation of these pro-poor policies constitutes the second side of the solution to improving health care service delivery in rural areas. While increased information and awareness are important in their own right as a form of political freedom (Sen 1999; Jenkins and Goetz 1999) and as a mechanism to directly improve health outcomes, they also undergird the formation and the implementation of pro-poor policies, which I discussed in Chapter 6. Pro-poor policies are an alternative to the clientelist policies that contribute to the disparities in India in health

outcomes between the poor and the better off. Pro-poor policies are based on addressing demand-side barriers and increasing community participation to monitor and evaluate health facilities, with the end goal of engaging the poor to actively strengthen the effectiveness of these policies. Furthermore, different information types play a central role in ensuring the different criterion of a pro-poor policy. The National Rural Health Mission, which is India's most recent attempt to completely transform the architecture of its health systems, is an example of an initiative that is actually pro-poor. It acknowledges the shortcomings of India's current health system, and contains a lot of the right ideas about how to improve the health system. However, where it has struggled is the implementation step due to a lack of political will. Government and NGO campaigns to increase awareness of this particular initiative could help to perhaps strengthen political will to implement provisions that are part of the National Rural Health Mission.

Together with information dissemination, pro-poor policies can address clientelism and the lack of accountability that together result in a weak public service delivery system in India, particularly in terms of health care to poor individuals in rural areas. Skewed political incentives can be aligned correctly through these two mechanisms, and the marginalized can collectively begin to express their grievances. Through information, these individuals can both improve their health directly and demand better health services from health providers and policymakers.

THE PATH FORWARD

The path forward can be divided into two areas: avenues for further research and proposals for the Indian government. In terms of future research, there are two different

projects that can be built directly off this study. While Chapter 4 advanced statistical evidence from a district in one state in India, starkly different contexts in different states in India necessitates an examination of the situation in each state. Therefore, the first proposal for further research is a subnational analysis of India that examines the effect of increased information about health entitlements (using health proposals and services as a proxy) and increased participation in associations in increasing interaction with government officials and health providers in each state. This would help to confirm the theory advanced in this study.

The second avenue for further research has to do with field experiments to solidify the theory and data advanced in this study. Randomized trials that implement a treatment intervention of increasing awareness of health entitlements among individuals in particular villages and a control group in other villages can help to identify with greater certainty the significance of increased information and participation in associations. Many organizations are already conducting similar work, and this is both a feasible and necessary next step.

In terms of policy proposals for the Indian government, the main recommendation is that there needs to be an increased focus on bottom-up solutions, particularly on information dissemination and participation in rural associations. Initiatives that engage civic society more and that recognize the importance of involving the poor in developing health policies are vital.

FINAL REMARKS

I am under no illusions that the arguments and the steps outlined in this study to improve India's rural health care system are by any means easy. To the contrary, the argument that I have put forth is perhaps one of the most difficult to implement, as it takes patience and direct contact with the very individuals that need improvements in their lives. However, it is this very notion of involving the poor in improving their own livelihoods that is the most important. This study has not been an exercise in pure idealism. Rather, it was developed with the intent of providing a framework through which the problem of inequalities in healthcare in India can most directly and effectively be addressed. At the same time, this study has not been simply an intellectual endeavor either. It is grounded in interactions with individuals who personally face barriers to adequate health care in Indian villages, case studies of organizations and government programs implementing the steps outlined in this thesis, and personal experience.

India itself is currently at a crossroads. It can either continue on the path of failure to fulfill its responsibility of providing sufficient health care to all its citizens, or it can turn a new chapter in its history by supplying its citizens with a basic human right essential to the development of its society. It is not enough to simply recognize this basic human right, and much depends on the ability of the government to actually implement what it promises. My hope is that this study can in some way contribute to the conversation and to the programs being implemented regarding how to empower the poor to demand and live fuller, healthier lives.

Appendix A

HEALTH SURVEY

Interviewer: Complete Before Beginning the Survey

1. Name of the Interviewer: _____
2. Signature of the Interviewer: _____
3. Date of Visit: _____
4. Starting Time of Survey: _____
5. Ending Time of Survey: _____
6. Location of Survey: Address: _____
   Mandal: _____
   Household #: ___ Village: _____
   Panchayat: _____

Section A: Demographics

A1. Name _____

A2. Age _____

A3. Gender: **1.** Male **2.** Female

A4. Marital status?

1. Married **2.** Unmarried
3. Living with someone, but unmarried **4.** Divorced/Separated **5.** Widowed

A5. Do you have any children? (***If yes***) How many children do you have, what is the age and gender of each, is he/she literate, what is their level of education, and have they had the following immunizations?

Child	Age	Sex	Literate?		Education	Delivery Location	Immunizations		
			Yes	No				Yes	No
			0	1			**Imm. Card**	0	1
							BCG	0	1
							DPT	0	1
							OPV/Polio	0	1
							Measles	0	1
			0	1			**Imm. Card**	0	1
							BCG	0	1
							DPT	0	1
							OPV/Polio	0	1
							Measles	0	1
							Imm. Card	0	1
			0	1			**BCG**	0	1
							DPT	0	1
							OPV/Polio	0	1
							Measles	0	1
							Imm. Card	0	1
							BCG	0	1
			0	1			**DPT**	0	1
							OPV/Polio	0	1
							Measles	0	1
							Imm. Card	0	1
							BCG	0	1
							DPT	0	1
			0	1			**OPV/Polio**	0	1
							Measles	0	1
							Imm. Card	0	1
							BCG	0	1
							DPT	0	1
							OPV/Polio	0	1
			0	1			**Measles**	0	1
							Imm. Card	0	1
							BCG	0	1
							DPT	0	1
							OPV/Polio	0	1
							Measles	0	1

A6. Level of education _____

A6a. ***(If Married)*** Level of education of husband/wife _____

A6b. Level of education of father and mother
Father: _____ Mother: _____

A7. Main occupation _____

A7a. ***(If Housewife)*** Do you help your family financially in any other way apart from fulfilling the domestic chores? **2.** Yes **1.** No **9.** NA

A7b. ***(If Married)*** Husband/wife's occupation? _____

A8. Caste/Jati-biradari/Tribe: _____

A8a. Caste group?

1. Scheduled Caste (SC) **2.** Scheduled Tribe (ST)
3. Other Backward Caste (OBC) **4.** Other

A9. Which religion do you follow?

1. Hindu **2.** Muslim **3.** Christian **4.** Sikh
5. Buddhist **6.** Jain **7.** Parsi **8.** Other ***(Specify)*** _____

Section B: Health Status

B1. Now I would like to ask you about some health conditions that people sometimes complain about. Have you experienced _____ in the last 30 days?

No		Experienced in the past 30 days?		*(If yes)* Is/was the condition serious?	
		Yes	No	Yes	No
1	**Cold symptoms**	0	1	0	1
2	**Dry cough**	0	1	0	1
3	**Productive cough**	0	1	0	1
4	**Cough with blood**	0	1	0	1
5	**Blood in spit**	0	1	0	1
6	**Hot fever**	0	1	0	1
7	**Diarrhea**	0	1	0	1
8	**Body ache**	0	1	0	1
9	**Weakness/fatigue**	0	1	0	1
0	**Problems with vision**	0	1	0	1
10	**Headache**	0	1	0	1
11	**Backache**	0	1	0	1
12	**Vomiting**	0	1	0	1
13	**Worms in stool**	0	1	0	1
14	**Trouble breathing**	0	1	0	1
15	**Pain in abdomen**	0	1	0	1
16	**Painful urination**	0	1	0	1
17	**Swelling ankles**	0	1	0	1
18	**Hearing problems**	0	1	0	1
19	**Skin problems**	0	1	0	1
30	**Chest pain**	0	1	0	1
21	**Memory loss**	0	1	0	1
22	**Full paralysis**	0	1	0	1
23	**Partial paralysis**	0	1	0	1
24	**Night sweats**	0	1	0	1
25	**Weight loss**	0	1	0	1

26	**Other (specify) _____**	0	1	0	1
	Female respondent:				
27	**Menstrual problems**	0	1	0	1
28	**White discharge**	0	1	0	1

B2. Have you had any of the following problems/surgeries?

1. Tuberculosis 2. Hysterectomy 3. Appendicitis 4. Tubectomy F. Vasectomy

B3. Where do you receive your water from?

1. Tap
2. Tube-well/hand pump
3. Pucca Well
4. Tank/pond reserved for drinking
5. River/canal
6. Bore well
7. Municipal
8. Other (specify) _____

B4. Where do you go for defecation?

1. Open air
2. Community Latrine
3. Latrine in house (septic tank)
4. In sanitary Latrine (Traditional)

If the respondent is female (IF NOT GO TO QUESTION C1):

B5. Did you ever have any of the following? ***(If yes)*** How many?

	Occurred?		*(If yes)* **How many?**
	Yes	**No**	
Stillbirth	0	1	
Spontaneous Abortion	0	1	
Induced Abortion	0	1	

B6. Have you had any children who have died in the period between their birth and this date? ***(If yes)*** How many and on what date?

2. Yes **1.** No **How many:** _____ **Date:** _____

Section C: Health Services

C1. How far is the subcenter from your home?

1. 0 to 5 kms **2.** 6 to 10 kms **3.** 11 to 15 kms **4.** More than 15 kms **8.** Don't know

C2. How far is the primary health center from your home?

1. 0 to 5 kms **2.** 6 to 10 kms **3.** 11 to 15 kms **4.** More than 15 kms **8.** Don't know

C3. How often have you or your family visited a government hospital in the past year?

1. Never **2.** 1 to 2 times **3.** 3 to 4 times **4.** More than 5 times **8.** Don't know

C4. When was your last visit to a health facility or consultation with a health provider?

1. <1 month ago **2.** 1 to 6 months ago **3.** 6 to 12 months ago **4.** 1 to 2 years ago **5.** 2+ years ago

C5. For whose health condition did you visit this health facility?

1. Own **2.** Spouse **3.** Child **4.** Parent **5.** Other

C6. Why did you visit a health facility or consult a health provider **(list conditions of illnesses or name of illness if known)**? _____

C7. Which type of facility did you visit, or which type of health provider did you consult?

CHC/PHC	1
GOVERNMENT REFERRAL HOSPITAL	2
PRIVATE HOSPITAL	3
AYURVEDIC HOSPITAL	4
T.B. HOSPITAL	5
DISPENSARY	6
SUBCENTER	7
ANGANWADI	8
ASHA WORKER	9
HEALTH CAMP	10
NGO CLINIC	11
PRIVATE QUALIFIED DOCTOR	12
PRIVATE COMPOUNDER/NURSE	13
PRIVATE PHARMACIST	14
GOVERNMENT DOCTOR, PRIVATE PRACTICE	15
OTHER GOVERNMENT PRACTITIONER, PRIVATE	16
TBA/DAI	17
BHOPA/TRADITIONAL HEALER	18
QUACKS	19
REG. MEDICAL PRACTITIONER (RMP)	20
DON'T KNOW	99
OTHER (SPECIFY– PUBLIC/PRIVATE)	96

C8. What is the name of the facility or health provider? _____ **8.** Don't know

C9. Where is this facility located, or where did you consult this health provider?

Village or town: _____ **Mandal:** _____ **District:** _____

If the visit was to GOVERNMENT facility (IF NOT, GO TO QUESTION C11):

C10. At your last visit to a public health facility, was any health provider there?

2. Yes **1.** No

C10a. At your last visit to a public health facility, how long did you have to wait before you could meet with a health provider? _____ **9.** NA

C10b. Who did you see at your last visit to the government facility?

GOVERNMENT DOCTOR/MEDICAL OFFICER	1
COMPOUNDER OR MALE NURSE	2
PHARMACIST	3
ASHA WORKER	4
ANM	5
STAFF NURSE	6
LADY HEALTH WORKER	7
LAB TECHNICIAN	8
RADIOGRAPHER	9
CLERK	10
PRIVATE QUALIFIED DOCTOR	11
PRIVATE COMPOUNDER/NURSE	12
PRIVATE PHARMACIST	13
TBA/DAI	14
BHOPA/TRADITIONAL HEALER	15
DON'T KNOW	999
OTHER (SPECIFIY – PUBLIC/PRIVATE)	996

C10c. Was going to a public facility the only option you or your family had, or did you choose to go to a public facility?

1. Only option **2.** Choice **8.** Don't know **9.** NA

C10d. What were the 2 main reasons for you or your family to decide to go to a government clinic instead of other medical care providers? ***(READ OUT answer categories 0 to 7) (CIRCLE ONLY 2 RESPONSES)***

0. Doctors and staff available
1. Quality of treatment was good
2. Good facilities such as medicines, beds, equipment etc.
3. Close geographically
4. Affordable/Free of cost
5. Attentive and caring staff
6. Previous experience with them was good
7. Medical emergency
8. Others ***(Specify)*** _____
9. NA

C10e. At the visit or consultation, did you (or the person who was ill) get the following resources? ***(If yes)*** Did you have to pay for the service, and how much?

	Did you get the resource?		**Did you have to pay for it?**		**How much?**
	Yes	**No**	**Yes**	**No**	
Consultation	0	1	0	1	
Medication given in facility	0	1	0	1	
Medication outside the facility	0	1	0	1	
Injection	0	1	0	1	
Operation	0	1	0	1	
Lab test	0	1	0	1	
Other treatment	0	1	0	1	
Transportation	0	1	0	1	
Total Expenses Incurred					

C10f. Was any extra money paid for the service? How much?

2. Yes **1.** No **9.** NA _____

C10g. Would you ever go back to this facility or visit this same health provider again if necessary? **2.** Yes **1.** No **8.** Don't know

C10h. ***(If no)*** Why would you not go back to this facility? _____

C10i. What is your overall assessment of your experience at the government hospital/clinic - would you say that you are satisfied or dissatisfied with it?

1. Fully satisfied **2.** Somewhat satisfied
3. Somewhat dissatisfied **4.** Fully dissatisfied **8.** Can't Say/D.K. **9.** NA

C10j. ***(If 'Dissatisfied')*** Did you think about complaining about your dissatisfaction?

2. Yes **1.** No **9.** NA

C10k. ***(If Yes)*** Did you complain to someone about your experience? ***(Go to C16)***

1. I did successfully complain
2. I wanted to complain but did not know where
3. I tried to complain, but could not
9. NA

If the visit was to a PRIVATE health facility:

C11. What were the 2 main reasons for you or your family to decide to not to go to a government clinic? ***(READ OUT answer categories 0 to 7) (CIRCLE ONLY 2 RESPONSES)***

0. Doctors and staff not available/absent
1. Quality of treatment not good
2. Lack of facilities such as medicines, beds, equipment etc.
3. Alternative medical care was closer
4. Alternative medical care was cheaper/more affordable
5. Staff not attentive or caring
6. Previous experiences not good
7. Medical emergency
8. Others ***(Specify)*** _____
9. NA

C12. Was the consultation a visit to the *bhopa*, or spiritual leader?

2. Yes **1.** No **9.** NA

C13. ***(If yes)*** How much did this visit cost in total (including transportation, fees, offerings, and other costs)? _____

C14. Was the visit to a private facility?

2. Yes **1.** No **9.** NA

C15. ***(If 'Visited')*** What were the 2 main reasons for you or your family to decide to go to a private clinic instead of other medical care providers? ***(READ OUT answer categories 0 to 7) (CIRCLE ONLY 2 RESPONSES)***

0. Doctors and staff available
1. Quality of treatment was good
2. Good facilities such as medicines, beds, equipment etc.
3. Close geographically
4. Affordable
5. Attentive and caring staff
6. Previous experience with them was good
7. Medical emergency
8. Others ***(Specify)*** _____
9. NA
10. Referral (by govt. staff/private)
11. Referral by gov. practitioner to own practice

C16. Suppose you or someone in your family had a serious ailment, would you go to a government hospital? **2.** Yes **1.** No **8.** Don't know/Not sure

C17. Have you ever tried to meet the following people? ***(If Yes)*** What is the frequency? What was your experience like - would you say that the person was attentive but not helpful, was attentive and helpful, was neither attentive nor helpful, the person was rude and treated me badly, or you couldn't meet the person you tried to meet?

	Yes	No	Frequency	*(If Yes)* Attentive, but not helpful	Attentive & helpful	Neither attentive nor helpful	Rude	Couldn't meet	NA
Sarpanch/Councillor	0	1		*(If Yes)* 5	4	3	2	1	9
Collector/District Magistrate	0	1		*(If Yes)* 5	4	3	2	1	9
District Health and Medical Officer	0	1		*(If Yes)* 5	4	3	2	1	9
PHC In-Charge	0	1		*(If Yes)* 5	4	3	2	1	9
Auxiliary Nurse Midwife (ANM)	0	1		*(If Yes)* 5	4	3	2	1	9
ASHA Worker	0	1		*(If Yes)* 5	4	3	2	1	9
Anganwandi Worker	0	1		*(If Yes) 5*	4	3	2	1	9

C18. Now I am going to read out the names of few government policies/schemes/services. Please tell me have you heard about them? Have you benefitted from them?

	Heard of them?		Benefited?	
	Yes	No	Yes	No
Right to Information (RTI)	0	1	0	1
National Rural Health Mission	0	1	0	1
National Tuberculosis Control Program	0	1	0	1
DOTS Program	0	1	0	1
Rogi Kalyan Samiti	0	1	0	1
Community Health Fund	0	1	0	1
Village Health Committee	0	1	0	1
PULSE Polio	0	1	0	1
Arogyasri	0	1	0	1
Other (please specify) _____	0	1	0	1

Section D: Community Participation

D1. Do you currently participate in or are you now a member of the following organizations? How often do you participate in these activities?

	Participate?			*(If yes)* Frequency?	
	Yes	No	DK		
Traditional Village Committee	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6

Village Health Committee	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6
Caste Committee	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6
Religious	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6
Women's Cooperatives (SHG's, etc.)	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6
NGO groups	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6
Youth club	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6
Other (specify)	0	1	8	**Daily**	1
				Weekly	2
				Few times a month	3
				Monthly	4
				Few times a year	5
				Annually	6

D2. Did you attend the last *Gram Sabah*? Why or why not? _____

2. Yes **1.** No

D3. Did you attend the last *Ward Sabah*? Why or why not? _____

2. Yes **1.** No

D4. ***(If the respondent is over 18)*** Did you vote in the last Panchayat election? **2.** Yes **1.** No

Section E: Politics and Socio-Economic Background

E1. On the whole would you say that politicians in the country are corrupt or they are not corrupt? *(If **'corrupt'**, probe further whether **'very'** or **'somewhat'** corrupt, and if **'not corrupt'**, probe further if **'not corrupt'** or **'not at all corrupt'**)*

.

1. Very corrupt **2.** Somewhat corrupt **3.** Not corrupt **4.** Not at all corrupt **8.** DK

E2. And what about your local Sarpanch/Counillor, would you say that she/he is corrupt or she/he is not corrupt? *(If **'corrupt'**, probe further whether **'very'** or **'somewhat'** corrupt, and if **'not corrupt'**, probe further if **'not corrupt'** or **'not at all corrupt'**).*

1. Very corrupt **2.** Somewhat corrupt **3.** Not corrupt **4.** Not at all corrupt **8.** DK

E3. Some people say that by and large politicians don't care for the interests of ordinary people, while others say that in democracy politicians do care for the interests of ordinary people. What is your opinion? **1.** Don't care **2.** Care **8.** No opinion

E3a. ***(If 'Don't care')*** What about your Sarpanch/Councillor, does she/he care about the interests of ordinary people or not? **1.** Don't care **2.** Care **8.** No opinion

E4. As compared to few years ago, how is the economic condition of your household today – would you say it has become much better, better, remained same, become worse or much worse?

1. Much better **2.** Better **3.** Same **4.** Worse **5.** Much worse **8.** No Opinion

E5. What do you think will be the economic condition of your household in the coming few years - would you say it will become much better, better, remained same, become worse or much worse?

1. Much better **2.** Better **3.** Same **4.** Worse **5.** Much worse **8.** No Opinion

E6. How satisfied are you with the economic condition of your household today? Are you satisfied or dissatisfied with it? *(Probe further whether **'fully'** or **'somewhat'** satisfied or dissatisfied).*

1. Fully satisfied **2.** Somewhat satisfied
3. Somewhat dissatisfied **4.** Fully dissatisfied **8.** Can't Say/D.K.

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